



Royal Commission
into Defence and Veteran Suicide

Health care for serving and ex-serving members

Volume 4

Final Report

Alex Seton

For Every Drop Shed in Anguish

made in Sydney, 2022–2023

Australian Pearl Marble

dimensions variable

Collection of the Australian War Memorial, acquired by commission in 2023

AWM2021.938.1

© Alex Seton

Together with veterans and their families, the Australian War Memorial commissioned this work of art to recognise and commemorate the suffering caused by war and military service. *For Every Drop Shed in Anguish* by Alex Seton provides a place in the Australian War Memorial's Sculpture Garden for visitors to grieve, to reflect on service experiences, and to remember the long-term cost of war and service.

Artist Alex Seton said, 'These rounded and abstracted liquid forms represent every drop of blood, sweat and tears ever shed by Australian military personnel and their families. It was very important that we create a different kind of memorial, not a singular heroic monument, but a grouping that acknowledges that there is a wider impact of mental and physical trauma. The large group of forms alludes to the suffering that radiates out from the individual, affecting their family, friends and communities.'

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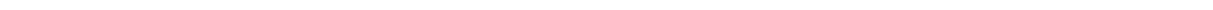


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Content warning – discussion of suicide and suicidality

This report is about suicide and suicidality among serving and ex-serving Australian Defence Force (ADF) members. It includes information related to these topics as well as experiences that have contributed to people becoming suicidal. This report includes content that readers may find distressing, confronting, emotionally-laden or otherwise difficult to read. You may find that reading this report brings up traumatic memories or strong emotional responses. We encourage you to speak with someone you trust, or you may wish to seek professional support through one of the services listed here if needed.

It is important to write about suicide, suicidality, traumatic experiences and their ramifications safely and responsibly. In the past, talking about suicide and suicidality has been taboo. We aim to approach our discussion about them in a constructive way. This report was written in line with our trauma-informed approach and using guidance from the Mindframe program.¹ We have aimed to avoid using language that might stigmatise suicide or suicidality or that might inadvertently encourage suicide. We recognise that because this report includes evidence and information provided by other people and organisations, there may be times when the language used does not always meet best practice guidelines.

Urgent support

If you require urgent or immediate help, you can:

- call triple zero (000)
- go to your local emergency department.

1 Mindframe, *A guide for media reporting on defence and veteran suicide*, 22 December 2022.

Crisis support services

Suicide Call Back Service

1300 659 467

24-hour counselling service for suicide prevention and mental health. Available via telephone, online and by video chat.

Open Arms

1800 011 046

24-hour mental health support for Navy, Army & Air Force personnel, veterans and their families.

Defence Member and Family Helpline

1800 624 608

24-hour service providing a range of practical and emotional support programs for families facing emergency or crisis.

Defence All-hours Support Line

1800 628 036

24-hour service for Australian Defence Force members and their families providing help to access military or civilian mental health services.

Lifeline Australia

13 11 14 or text 0477 13 11 14

24-hour crisis support service. Available via telephone, online and text chat.

Beyond Blue

1300 224 636

24-hour counselling service. Available via telephone, online or email.

1800RESPECT

1800 737 732

24-hour counselling service for sexual assault, family and domestic violence.

Men's Referral Service

1300 766 491

24-hour counselling, information and referral service for men concerned about their own use of violence or abusive behaviour.

MensLine

1300 78 99 78

24-hour support for men with concerns about mental health, anger management, family violence, addiction, relationship stress and wellbeing. Available via telephone, online and by video chat.

13YARN

13 92 76

24-hour national support line for First Nations people in crisis.

QLife

Call 1800 184 527 or visit qlife.org.au

The QLife phone and webchat service is available 3pm to midnight every day, providing space for where LGBTQI+ people and their loved ones can talk about anything affecting their lives.

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Part 5

Health care for serving and ex-serving members

14 Introduction to health care for members and veterans

Summary

Health care is integral to reducing suicide among serving and ex-serving Australian Defence Force (ADF) members.

Military service is associated with an increased likelihood of developing certain physical and mental health conditions that can be risk factors for suicide and suicidality. These include anxiety and depression, post-traumatic stress disorder, substance use disorder, chronic pain, brain injury, sleep disturbance, problematic anger, social isolation and moral injury.

Serving and ex-serving members experiencing one or more of these conditions need timely access to early intervention and treatment, and quality care. We know that risk factors for suicide and suicidality accumulate and compound, making this all the more crucial.

Serving and ex-serving members should be able to expect that they will receive care for illnesses, injuries and conditions they have developed while serving their country. Despite this, we have found serious issues with the quality, timeliness and effectiveness of health care provided to them.

Many of these arise from systemic problems with the Defence and veteran healthcare systems. These systems are highly complex, involve multiple actors and are largely separate from one another. Lack of coordination is a significant problem within and between the systems, particularly when a member separates from the ADF and shifts from health care provided by Defence to systems of veteran health care.

This is the first of nine chapters in Part 5, Health care for serving and ex-serving members. Each chapter in this part describes specific challenges we have identified in different aspects of the healthcare system.

This chapter discusses system-wide issues that affect access to quality, appropriate health care for serving and ex-serving members. These include:

- the dilution of military health expertise and care
- a lack of cultural competency in civilian health services
- the need for stronger partnering to share clinical knowledge and translate research into practice.

To help address these challenges, we recommend that the Australian Government take steps to support the establishment of a research translation centre (or a similar body) for Defence and veteran health care. Its purpose would be to share expertise and promote good practice across the health systems providing health care to serving and ex-serving members.

The centre would bring together staff from Defence and the Department of Veterans' Affairs (DVA), researchers and health professionals. Its remit could be to publish accessible information and research, set up infrastructure to enable networks and partnerships, and potentially support education and training.

14.1 Why health care matters

1. Our terms of reference require this Royal Commission to examine matters including:

the availability, accessibility, timeliness and quality of health, wellbeing and support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services.¹
2. The quality, availability, accessibility and effectiveness of health care is important to the issue of Defence and veteran suicide. In Chapter 1, Understanding suicide, we set out the risk factors that are associated with a higher likelihood of suicide and suicidality, and the protective factors that reduce that likelihood or mitigate one or more risk factors. Several of these factors relate to health and health care.
3. Previous reports have identified several risk and protective factors that relate to health and health care. The Interim National Commissioner for Defence and Veteran Suicide Prevention's *Preliminary Interim Report* (the Boss Report), for example, identified the following health conditions as risk factors: post-traumatic stress disorder (PTSD), traumatic brain injury, moral injury, inadequate sleep, anxiety and depression, schizophrenia and bipolar disorder, chronic pain, anger, and alcohol misuse.²
4. The Boss Report states that access to appropriate mental health services can be protective, while a lack of access to timely and effective mental health support can be a risk.³
5. The Australian Commission on Safety and Quality in Health Care undertook a thematic analysis of the records of 461 serving and ex-serving unique suicides to identify common themes. The analysis identified mental and physical health issues as a key theme.⁴
6. The analysis found that 'mental health issues were widely experienced and were the most pervasive set of issues relating to suicide death'.⁵ It found that 83% of ex-serving members who died by suicide had mental and behavioural disorders.⁶ The second and third most common conditions identified were musculoskeletal conditions and disorders associated with injury (including PTSD, traumatic brain injury, chronic pain and cognitive impairment), respectively.⁷

7. The onset of these conditions can often be prevented or the severity reduced through effective prevention, early intervention and treatment. The thematic analysis did show instances of help seeking and engagement with support services. However, for some individuals, this engagement was sporadic, leading to discontinuity of care because they disengaged, did not pursue their treatment plan or faced delays in accessing services.⁸
8. In its 2021 *Final Report to the Independent Review of Past Defence and Veteran Suicides*, the Australian Institute of Health and Welfare (AIHW) noted how health care could affect Defence and veteran suicide. It found that 'the frequency, type and timing of access to ... [health] services can also be risk or protective factors affecting suicide outcomes' for Australian Defence Force (ADF) members.⁹
9. Research by the Centre for Mental Health at the University of Melbourne commissioned by this Royal Commission identified 'barriers to accessing mental healthcare (local)' as a known risk factor for suicidality, while ease of accessibility to mental health treatment has been identified as a protective factor.¹⁰
10. In addition, research by Flinders University commissioned by this Royal Commission found that deployment injuries and trauma (physical and mental) did not necessarily lead to suicidality, but the way in which those injuries were managed by the ADF and the Department of Veterans' Affairs (DVA) did.¹¹

14.1.1 Risk and protective factors interact with each other

11. In Chapter 1, we explore the complex drivers of suicide and suicidality. As the chapter notes, suicidality is complex, with multiple interconnected factors that contribute to suicide and suicidal behaviours.
12. These dynamics are at play in the factors associated with health and health care. Here, we see how interrelated factors around health conditions and their treatment affect the likelihood of suicide and suicidality as outcomes for people. Efforts to prevent suicide require an understanding of these factors and how they interrelate.
13. Other factors also interact with health and health care. In Chapter 7, Culture and leadership, and Chapter 15, Promoting health and wellbeing among ADF members, we explore aspects of military culture, including self-reliance, stoicism and the stigma surrounding perceived weakness – epitomised in the charge of 'malingering'. These can act as powerful barriers to members accessing health care and mental health support, even when they need it. It is essential that efforts to promote health and health care take into account (and respond to) these aspects of military culture.
14. Norms and traditions of military culture themselves also contribute to health conditions. Research undertaken for this Royal Commission identified a 'consistently dominant alcohol culture' within the ADF (which we discuss in Chapter 7), and also cited alcohol misuse as a risk factor for self-harm and suicidality.¹² While the culture of regular binge drinking may have lessened somewhat in recent years, we have nevertheless heard from many people with lived experience that it is still prevalent in many settings, including in training facilities and on bases.¹³

15. Some risk factors may also be intrinsic to an individual. The Boss Report, for example, identified biological factors, including genetic variants, as risk factors, as well as schizophrenia and bipolar disorder, for which there may be genetic predisposition.¹⁴ Likewise, some people enlist in the ADF with existing physical and mental health conditions, which they may or may not have disclosed.¹⁵ The existence of these factors must be recognised, understood and used to inform prevention strategies and health care.
16. In Chapter 3, Recruitment and initial training, we discuss the increasing number of medical waivers (relating to physical or mental health) that allow candidates to enlist who would not otherwise meet minimum standards – particularly since 2016.¹⁶ This means that more people with known physical and mental vulnerabilities are permitted to enlist, further increasing the necessity of excellent health care.

14.2 The healthcare needs of serving and ex-serving members

17. Given the large number of Australians who serve or have served in the military, the task of providing health care to serving and ex-serving members is significant. Their health profile is different from the general Australian population, with serving and ex-serving members more likely to experience certain health conditions. This section outlines some of these conditions, including their links to suicide and suicidality, and the implications for treatment and support.

14.2.1 The treatment population

18. The number of serving and ex-serving members requiring health care is large. In the 2021 Census, 581,139 people identified as having served, or as currently serving, in the ADF.¹⁷
19. The provision of health care in this context represents a significant endeavour. For serving members, 1,758 full-time equivalent clinical and administrative staff provided on-base health services as at 29 March 2022.¹⁸ Members may also use off-base health services.
20. The number of eligible veterans and dependants who have been issued a White Card or Gold Card entitling them to DVA-funded health care is large and growing. In September 2023, 286,591 veterans and dependants had been issued with these cards.¹⁹ This is an increase of 30% in 10 years, as compared to the population of 220,302 in 2013.²⁰
21. These figures alone do not reflect the full scope of healthcare requirements, as many ex-serving members also access health care using Medicare, private health insurance or their own funds.

14.2.2 The health profile of serving and ex-serving members

22. The health profile of Australia's serving and ex-serving members differs from that of the general population.
23. As we explore in Chapter 1, Understanding suicide, the serving ADF population is, on average, healthier than the general population. This is thought to be because:
 - The ADF does not permit candidates with certain conditions to enlist.
 - ADF members are provided access to health care at no cost.
 - The ADF offers physical conditioning programs and some programs to foster good mental health.²¹
24. However, military service also exposes members to unique stressors, which we describe in Part 2, Serving the nation, and Part 3, Misconduct, complaints and military justice. These chapters examine the organisational and operational stressors of ADF service life. Stressors may include intense physical activity, the high operations tempo, substance use, physical trauma, psychological trauma, frequent relocations, lack of recovery time following deployment, military interpersonal violence, military sexual violence, a perceived lack of procedural fairness in the complaints handling system, and exposure to toxic substances. Exposure to these stressors can significantly affect health outcomes, including as they relate to risk factors for suicide.
25. This dynamic is explained in research produced by the University of Melbourne, undertaken for this Royal Commission:

there are also likely to be differences in the suicide risk factor profile, (as well as the broader health risk factor profiles) of serving and ex-serving populations compared to the general population that may, in part, be attributed to exposure to the defence life experience. While those in the defence services are trained for physical and mental fitness and benefit from access to comprehensive healthcare, there are unique workplace stressors and experiences such as exposure to combat, periodic geographical relocations, separation from family, and exposure to life threatening situations that may contribute to mental trauma and moral injury.²²

Members may have more complex health needs

26. As they form a very large population, the health of serving and ex-serving members varies; it is important to emphasise that many members are very healthy. However, data and research seen by this Royal Commission suggest that those who have served in the ADF may be more likely to experience particular health conditions, including mental health conditions.
27. This is important to note, as some health conditions are known risk factors for suicide and suicidality. It may also have implications for efforts to prevent, treat and support these conditions.

Overall health status

28. In the 2020–21 National Health Survey run by the Australian Bureau of Statistics, most male participants aged 18 or over who had ever served in the ADF self-rated their health as ‘good’, ‘very good’ or ‘excellent’.²³
29. However, men who had ever served in the ADF were less likely to self-rate their health as ‘excellent’ or ‘very good’ (at 45%) compared to those who had never served (at 57%).²⁴

Long-term physical health conditions

30. According to the 2021 Census, 60% of ex-serving members reported having a long-term health condition.²⁵ Among the broader Australian population aged 15 and above, this figure was 36%.²⁶
31. Data from the 2020–21 National Health Survey also showed that men 18 or over who had served in the ADF had a higher prevalence of some long-term health conditions, compared with those who had never served. This included higher rates of:
 - arthritis (33% compared with 12%)
 - back problems (31% compared with 19%)
 - heart, stroke and vascular disease (15% compared with 5.9%)
 - diabetes (14% compared with 6.9%)
 - cancer (6.7% compared with 2.6%).²⁷

Mental health conditions

32. Data from the 2020–21 National Health Survey also showed a higher prevalence of some mental health and behavioural conditions among those who had served in the ADF. Among men 18 or over who had ever served:
 - 27% have had a mental or behavioural condition, compared with 17% of men who had never served
 - 21% reported having an anxiety-related disorder, compared with 11% of men who had never served.²⁸
33. Twelve per cent of men who had served reported having had depression or feeling depressed, compared with 9.4% of those who had never served.²⁹

14.2.3 Health conditions associated with higher suicide risk

34. In our inquiry, we identified health conditions that are prevalent in serving and ex-serving members that are associated with increased suicide risk. In doing so, we aim to highlight the importance of prevention, early intervention and treatment services in managing, if not preventing, these conditions.
35. Each condition has its own unique characteristics and associated risks. None on its own will necessarily lead to suicidality or suicide, but some may be experienced at the same time as – or be associated with the later development of – others. For example, physical ill health can be associated with later-onset mental health conditions.³⁰ The co-occurrence of health conditions, where an individual experiences more than one at the same time, is common.³¹

Anxiety and depression

36. Anxiety and depression – whether experienced separately or together – are strongly associated with increased suicide risk.
37. According to the AIHW's Suicide Monitoring Report, mood disorder (such as, but not limited to, depression) was the most common risk factor associated with suicide among both male and female ADF members.³² A DVA-commissioned study estimated that almost half (46.4%) of ADF members who transitioned from full-time service had experienced a mental health condition in the previous 12 months, with anxiety disorders being the most common.³³
38. Generally, individuals who have gone through adverse life events such as unemployment, relationship breakdowns, bereavement or traumatic events are more likely to develop depression.³⁴
39. There are effective treatments for depression and anxiety, and steps that can be taken to reduce the effects of symptoms.³⁵

Post-traumatic stress disorder

40. Research into the suicide of ADF serving and ex-serving members indicates that, among Australian veterans, the risk of attempting suicide increased with the severity of PTSD symptoms.³⁶ This is consistent with international evidence, which shows that PTSD diagnosis and high severity of PTSD symptoms are both associated with suicide.³⁷
41. Many members told us they were diagnosed with PTSD during or after service.³⁸ In fact, the Mental Health and Wellbeing Transition study found that a quarter (24.9%) of transitioned ADF members were estimated to have met the criteria for PTSD in their lifetime.³⁹ This is consistent with AIHW research that found that cumulative exposure to work-related traumatic events is associated with an increased risk of PTSD.⁴⁰

42. We note that PTSD is not an inevitable consequence of experiencing a potentially traumatising event. It is not fully understood why one person develops PTSD and another does not; however, several risk factors have been identified. These include being exposed to trauma earlier in life, multiple exposures to traumatic events, an absence of social support after trauma, and the presence of other major life stressors.⁴¹
43. DVA provides guidance on effective, evidence-based treatments for PTSD.⁴²

Substance use disorder

44. When a person has a substance use disorder, it means that they overuse alcohol, prescription medications and/or legal or illegal drugs, sometimes at dangerous levels.⁴³ Having a substance use disorder is associated with higher rates of suicide in military populations.⁴⁴ Risk varies according to the substance. International research suggests that opioid and cannabis use lead to the biggest risk.⁴⁵
45. However, research from the AIHW identifies alcohol use as being of particular concern among Australian military personnel. Data from the AIHW highlights acute alcohol use and intoxication as risk factors for suicide, with acute alcohol consumption and intoxication being linked to 28.4% of suicide deaths among male ADF members, a rate greater than that of the general population.⁴⁶
46. The Transition and Wellbeing Research Programme estimated in 2018 that 12.9% of transitioned members had experienced alcohol use disorder in the previous 12 months, and 47.5% had experienced alcohol use disorder over their lifetime.⁴⁷
47. In addition to being a risk for suicide and suicidality in its own right, intoxication is strongly associated with certain forms of unacceptable behaviour, including military interpersonal violence and military sexual violence.⁴⁸ We discuss this in Chapter 9, Unacceptable behaviour and complaints management.
48. Many serving and ex-serving members told us of the effect substance use had on them.⁴⁹ A number of submissions discussed substance abuse in the context of suicidal ideation. Submissions also revealed a strong drinking culture within the ADF, though over time this appears to be lessening.⁵⁰
49. Many serving and ex-serving members told us that substance abuse was a coping mechanism they used to escape temporarily from mental or physical suffering.⁵¹ As is the case with many of the other mental health conditions discussed in this section, substance use disorder can be effectively treated. Prevention and early intervention programs can also be effective in addressing substance use at an early stage before it becomes a problem.

Chronic pain

50. Chronic pain has been linked to suicide ideation, suicide behaviour and death by suicide among veterans and the broader community.⁵²
51. Chronic pain is generally understood as pain lasting more than 3 months, or as pain where the injury or disease which originally caused it has resolved.⁵³ Evidence suggests that severe pain is more strongly correlated with suicidality, and pain becomes a particularly significant risk factor when it becomes chronic.⁵⁴
52. The Transition and Wellbeing Research Programme found that 90% of serving and 88% of transitioned members experienced some level of pain.⁵⁵ Of this, 31.7% of ex-serving members and 23.1% of serving members reported pain that was either high-intensity or highly disabling.⁵⁶ This is consistent with the Impact of Combat study conducted by Defence and DVA, which found that only 10% of permanent ADF members who had deployed to the Middle East Area of Operations reported being 'pain free'.⁵⁷
53. We also heard extensive evidence of the high rates of injuries experienced by serving ADF members, particularly in training. We discuss this issue in Chapter 3, Recruitment and initial training, going into the connection between training injuries and early separation from the ADF (including voluntary separation and involuntary medical separation) as risk factors for suicide and suicidality.
54. We heard evidence that pain is both a risk factor for suicidality and a mediating factor that links other risk factors, such as medical discharge and PTSD, to suicide.⁵⁸ Dr Stephan Rudzki, a former uniformed medical officer now practising privately as a sports and exercise physician, told us that if he cannot control the pain of patients with comorbid PTSD, 'their PTSD symptoms will rarely improve'.⁵⁹
55. We heard from many ADF members who live with chronic pain as a result of service.⁶⁰ Serving and ex-serving members told us that the lived experience of pain contributes to social isolation, feeling like a burden, hopelessness and loss of identity, as well as exacerbating other risk factors such as PTSD, depression, anxiety, substance use and poor sleep.⁶¹
56. In Chapter 15, Promoting health and wellbeing among ADF members, we examine injury prevention in the ADF. Here, we stress its importance alongside the effective treatment and rehabilitation of injuries to prevent chronic pain developing. Chronic pain disrupts serving and ex-serving members' everyday life, and is one way physical injuries can lead to mental ill health. This is amplified when ADF members feel let down by the systems that are meant to support them.

57. One member told us:

I am angry because I feel my injury could have been prevented in the first place and that there is a lack of care about fundamental occupational health and safety in the military workforce. I have experienced continuous depression; life is miserable now for me. Each day I feel exhausted and in pain. I have struggled with thoughts of suicide most days.⁶²

58. It is common for people in chronic pain to feel angry, which is itself associated with negative social, clinical and functional outcomes.⁶³ While it is difficult to attribute causality, there is evidence that when someone perceives an injustice, such as the member quoted above who felt their injury was preventable, they are more likely to report pain of greater intensity, and poorer health and mental health outcomes, including PTSD.⁶⁴

59. Some members attributed the poor management of injuries and resulting chronic pain to aspects of military culture and policy that act as barriers to seeking support and treatment. These include the extreme value placed on stoicism; a culture of toughness and 'sucking it up', which encourages a high tolerance of pain; the real fear of judgment and ostracism if one is ill or injured; and the justified fear of a medical downgrade that can impact deployability, career progression and remuneration. As the following submission author wrote:

During my training I developed bilateral stress fractures of the tibia and was warned I would be back squaded [re-assigned to another platoon] if I could not get out of the medical centre and back to my platoon. I sucked it up and managed to convince the doctor that I was no longer in pain and was allowed to return to my platoon.⁶⁵

60. Issues related to stigma and barriers to seeking help, and the consequences of the military employment classification are discussed in Chapter 15 and Chapter 5, The military employment classification system and medical separation, respectively.

Brain injury

61. Traumatic brain injuries are associated with a heightened risk of death by suicide in veteran and civilian populations, according to research we commissioned.⁶⁶ This is potentially due to a change in cognitive factors, including reduced capacity for higher-order cognitive function, increased impulsivity, and mild cognitive impairment and dementia.⁶⁷ It could also be due to demographic variables such as reduced employment, financial strain and relationship difficulties.⁶⁸

62. Research from the Australian Commission on Safety and Quality in Health Care found that traumatic brain injury that occurred during or as a result of service made transition to civilian life harder. It was found to be correlated with poor wellbeing and loss of sense of self, which often compounded later-onset mental illness.⁶⁹

63. International research suggests that military personnel risk sustaining multiple traumatic brain injuries from training activities and combat activities.⁷⁰ Traumatic brain injury in serving members is most commonly caused by falls, motor vehicle accidents, violence (including gunshot wounds and assaults), head impacts while playing contact sports, exposure to explosive blasts and heavy munitions firing, and other combat injuries.⁷¹ Around 80% of all traumatic brain injuries suffered by serving members are considered 'mild'.⁷²
64. Traumatic brain injury from blast exposure is common in active-duty military personnel.⁷³ Many researchers believe that the pressure wave passing through the brain significantly disrupts brain function, causing damage.⁷⁴
65. The type, number and severity of injuries sustained by military personnel have changed over time as weapon and armour technology and styles of combat have evolved. In the conflicts in Iraq and Afghanistan, mild traumatic brain injury was the most common injury among US military personnel, leading to its being labelled the 'signature injury'.⁷⁵ A 2020 study of US personnel reported that traumatic brain injury is most prevalent in the Army.⁷⁶
66. Research published by Defence and DVA found that among a group of ADF members deployed to the Middle East Area of Operations, the most commonly reported context for experiencing a head injury was blast exposure – being nearby when an explosion or blast occurred.⁷⁷
67. Ms Denise Goldsworthy AO, Chair of the Navy Divers Clearance Trust, gave evidence that clearance divers are regularly exposed to blasts, which can result in traumatic brain injury. Ms Goldsworthy told us of many conversations she has had with clearance divers who report experiencing anger issues and other strong negative emotions. This may be due to diagnosed or undiagnosed brain injuries.⁷⁸
68. Mr Geoffrey Evans joined the Army in 1994. In 2010, while deployed in Afghanistan, Mr Evans was wounded by a bomb blast, which left him with a back and brain injury. He was subsequently diagnosed with PTSD.⁷⁹ We also received submissions that link accidents during service to traumatic brain injury.⁸⁰
69. Serving and ex-serving members reported receiving insufficient support from the ADF for brain injury and having difficulty obtaining compensation from Comcare and DVA for these injuries, sometimes resulting in suicidality.⁸¹
70. Research on traumatic brain injury is evolving and the evidence base is growing. Box 14.1 outlines the role of the Australian Veterans' Brain Bank in developing greater understanding.

Box 14.1 The Australian Veterans' Brain Bank

Launched in January 2023, the Australian Veterans' Brain Bank is a collaboration between the Neuropathology department of Royal Prince Alfred Hospital, and the National Centre for Veterans' Healthcare at Concord Hospital, Sydney.

It is a tissue bank that is dedicated to research on disorders of the brain in people who have served in the ADF. It is a sister brain bank to the Australian Sports Brain Bank and part of the Concussion Legacy Foundation Global Brain Bank initiative.

It uses donor tissue to facilitate research into chronic traumatic encephalopathy and other brain disorders associated with brain trauma to understand the range of physical brain injuries occurring in Australian veterans.

Chronic traumatic encephalopathy

71. Studies have found a connection between traumatic brain injury and chronic traumatic encephalopathy (CTE).⁸²
72. CTE is a neurodegenerative disorder caused by single, episodic or repetitive blunt force impact to the head and the transfer of acceleration–deceleration forces to the brain.⁸³ Studies suggest that repetitive closed-head impact injuries (independent of concussion) and blast exposure may trigger early CTE brain pathologies.⁸⁴
73. CTE has been documented in athletes playing contact sport, victims of domestic violence, and people with epilepsy, as well as serving and ex-serving members who have experienced blast exposure.⁸⁵
74. Whether blast exposure produces unique patterns of damage that differ from those associated with impact-induced, non-blast traumatic brain injuries has been explored in research but requires further study.⁸⁶
75. Currently, CTE has no established diagnostic criteria during life, meaning that it can only be decisively diagnosed in a post-mortem.⁸⁷ The clinical symptoms that have been identified include 'mood disturbances, loss of impulse control, impaired memory, headache, language deficits, visuospatial difficulties, executive dysfunction, and global cognitive decline'.⁸⁸ In younger individuals, symptoms are predominantly behavioural, while in older individuals, symptoms are predominantly cognitive.⁸⁹ CTE is associated with suicidality.⁹⁰

Understanding brain injury

76. It is important that Defence work with experts to fully understand service risks associated with brain injury and commit to preventing and minimising them.
77. In support of this, Defence and DVA should develop a comprehensive brain injury program. This should take place across relevant Army corps, special forces, Navy clearance divers and Air Force combat controllers.
78. The program should monitor and assess environmental exposure to blast overpressure and ensure that exposures to events potentially leading to traumatic brain injury are recorded, including in medical records.
79. It should support members who have experienced traumatic brain injury, including by:
 - comprehensively assessing them
 - committing to address these silent injuries, informed by the latest research
 - enabling referral pathways for medical treatment.
80. It should support members experiencing neurocognitive issues we discuss in Chapter 22, Mefloquine and tafenoquine.
81. Defence and DVA should work collaboratively to establish the program, as it is designed to support all veterans living with traumatic brain injury.

Recommendation 61: Establish a brain injury program

Defence and the Department of Veterans' Affairs should establish a brain injury program that covers, at a minimum, relevant Army corps, special forces, Navy clearance divers, Air Force combat controllers, and serving and ex-serving members exposed to mefloquine and/or tafenoquine. The program should:

- (a) aim to better understand, and mitigate, the impact of repetitive low-level blast exposure on brain processes
- (b) assess and treat neurocognitive issues affecting serving and ex-serving members, whatever their cause.

To do this, it should:

- (c) monitor and assess environmental exposure to blast overpressure
- (d) record members' exposure to traumatic brain injury and minor traumatic brain injury, including in medical records
- (e) establish a neurocognitive program suitable for serving and ex-serving members experiencing a range of neurocognitive issues, whatever their cause. This could be adapted from the former Mending Military Minds program
- (f) provide referral pathways for further medical assessment, when required.

Sleep disturbances

82. Having sleep problems is a specific risk factor for suicidal ideation in ADF members.⁹¹
83. Research we commissioned found that having sleep problems is an independent risk factor for suicide ideation, suicide attempt and death by suicide. It found that nocturnal wakefulness increases the risk of suicide death, while clinical and subjective sleep disturbance increase the risk of suicide ideation in serving and ex-serving members.⁹²
84. Research has found several likely mechanisms for the link between poor sleep and suicidality, including nightmares, loneliness and poor mood regulation.⁹³
85. In their submissions, many serving and ex-serving members described difficulty sleeping due to physical or mental ill-health, trauma from combat or abuse, and the high work tempo making it difficult to 'stand down'.⁹⁴ The reported impacts of these sleep issues ranged from suicidal ideation and suicide attempts to depression and substance abuse, which themselves are risk factors.⁹⁵
86. Defence recognises that 'sleep is necessary to sustain good health and wellbeing'.⁹⁶ It accepts that 'sustained Defence operations often demand high-level cognitive functioning, wakefulness and vigilance over a prolonged period of time'.⁹⁷
87. Some commanders appear to be taking steps to ensure that members get enough sleep. For example, Commodore Heath Robertson CSC ADC RAN, a Shore Force Commander, said he had instigated 'fatigue management calculators' that applied to everyone and required them to get 'a minimum amount of sleep'.⁹⁸
88. Defence's Professor of Military Mental Health, Professor Jennifer Wild, is investigating the prevalence and underlying causes of sleep disturbances in the Defence community so as to design effective intervention tools.⁹⁹
89. In Chapter 15, Promoting health and wellbeing among ADF members, we recommend that sleep disturbance be included in the mental health screening continuum. In Chapter 17, ADF and DVA suicide prevention programs and initiatives, we discuss suicide prevention training, emphasising the role commanders play in managing members' fatigue and calling for a stronger link to be made between inadequate sleep and suicide risk.

Problematic anger

90. While anger is a normal and healthy emotion, the expression of it that we are calling 'problematic anger':

occurs at a frequency, intensity, or duration which compromises cognitive function and perception, causes significant distress or interferes with general functioning or interpersonal relationships or is associated with aggressive behaviour.¹⁰⁰

91. Anger and aggression are symptoms frequently associated with many psychiatric disorders, including anxiety and PTSD.¹⁰¹
92. Problematic anger was the subject of research commissioned by Joint Health Command and conducted by Phoenix Australia, as reported in 2022 in the Wellness Action Through Checking Health (WATCH) project. It found that the prevalence of problematic anger correlates with length of service. While 85% of early-career members did not report experiencing frequent anger, this fell to 23% for long-career members (those with over 16 years of service).¹⁰²
93. Problematic anger contributes to suicidality.¹⁰³ In 2022, Senior Research Fellow Dr Tracey Varker and others at the University of Melbourne conducted a study with Phoenix Australia, *Problem Anger in Veterans and Military Personnel: Prevalence, Predictors, and Associated Harms of Suicide and Violence*. It investigated the relationship between problem anger, suicidality and violence among veterans and military personnel. It found a significant correlation between problematic anger and suicidal ideation and plans.¹⁰⁴
94. It is important to recognise that anger is a healthy and justified emotion when someone has been wronged. It may be compounded by the response to a 'wrong', like how a complaint is handled, or whether someone is afforded procedural fairness.
95. For this reason, we do not want to problematise all expressions of anger in serving and ex-serving members. When an injustice has not been acknowledged or corrected, however, anger can become entrenched and be expressed in inappropriate ways to inappropriate people. This is what needs to be better understood and mitigated.
96. It is also important that steps are taken to manage the link between problematic anger and suicidality. In Chapter 15, for example, we recommend that problematic anger be included in the mental health screening continuum to increase awareness of it and so additional support can be provided.

Social isolation

97. Social isolation is linked to various health risks. It can affect 'psychological processes, such as a sense of meaning and purpose'.¹⁰⁵ Also, people who are more socially connected are more likely to seek help during times of stress.¹⁰⁶
98. There is a strong research base that shows a correlation between social isolation and suicide.¹⁰⁷ Conversely, social connection is a protective factor against suicide, especially among men.¹⁰⁸
99. The WATCH Project identified 'poor social support' as one of the four 'primary modifiable predictors' of distress and PTSD.¹⁰⁹
100. Social isolation may be linked to particular aspects of military service. As we outline in Chapter 3, Recruitment and initial training, following recruitment, new members are removed from their social supports and placed in a stressful training environment.

101. Postings and deployments can also involve significant disruption. Ms Kate Jenkins AO, Australia's Sex Discrimination Commissioner from 2016 to 2023, said that 'working in Defence has unique social conditions ... [including] deployments, regular posting cycles, [and] social conditions that impact families' movement and take people away from their homes and support services'.¹¹⁰
102. A member of the Air Force, quoted In Phoenix Australia's 2022 *Wellness Action Through Checking Health: WATCH Project Report*, said of the impact of this disruption:
- After seven or eight moves you get to a point where you're just like, I won't bother making friends cause we're just going to post again and it's all gonna be too hard to say goodbye and then start again.¹¹¹
103. In Chapter 27, Importance of families, we explore how service impacts Defence families. We note that serving and ex-serving members face unique challenges in their personal relationships brought on by stressors like frequent separation of members and their partners, and feelings of isolation, lack of intimacy and support due to time apart.¹¹²
104. In Chapter 23, Transition from military to civilian life, we explore how transition from military to civilian life can cause social isolation among some members. This can occur because of loss of identity, difficulty maintaining friendships that were formed in the ADF, and disconnection with civilian friends resulting from one's service. These can cause significant risks of social disconnection and alienation.¹¹³
105. A number of our recommendations seek to foster social inclusion. In Chapter 3, we recommend that Defence build a 'model of support' that would enable more peer support. In Chapter 4, Postings and deployments, we recommend measures to provide stability and certainty around postings and limit impacts on member and family wellbeing, including by reducing the frequency of relocation. In Chapter 23 we recommend that Defence establish a consistent policy for base access with the objective of supporting members and their families to maintain social connection during the transition to civilian life. We also recommend that DVA develop a cultural transition program which, among other objectives, aims to help members sustain social connections. Finally, in Chapter 27 we recommend that Defence improve the support available to Defence families.

Moral injury

106. Moral injury describes 'the strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code'.¹¹⁴ It lies on a continuum between 'moral distress', which may be less intense, or short-lasting, and 'moral trauma', which is a severe and long-lasting experience.
107. Moral injury can have emotional, psychological, social, behavioural and spiritual effects on a person, profoundly affecting their sense of self and others, as well as their worldview and belief system.¹¹⁵ It can, though does not necessarily, follow from witnessing something that transgresses one's moral code, or from perpetrating or being the victim of an action that transgresses one's moral code.

108. Unlike PTSD, which is associated with threat-based trauma, moral injury may not arise in the context of individual threat, or with the emotion of fear. Instead, it involves other strongly felt emotions, such as shame and guilt, which can erode the person's deeply held beliefs and trust.¹¹⁶
109. Research we commissioned found that the interaction between moral injury and PTSD was a significant predictor of suicide ideation and suicide attempt. It also found that identifying strongly with one's failures could strengthen the association between moral injury and suicidality.¹¹⁷
110. As one former serving member who had been [redacted] said:
- I don't see many people with suicidal ideation that want to kill themselves because of their post-traumatic stress. It's been described by people: 'I feel like I have a wounded soul, that I've done something really wrong or I witnessed something that was really wrong and I didn't do anything about it'. And this is my life experience: these are the things that lead to veterans' suicide.¹¹⁸
111. However, there is little research on the extent of moral injury in the ADF, despite international research suggesting that 'morally injurious events' are commonly experienced among defence populations.¹¹⁹
112. It is important that this emerging area be given more attention as the research into moral injury develops. For this reason, it is explored in more detail in Chapter 21, Moral injury.

14.2.4 Treatment and support for those with health conditions

113. It is critical that serving and ex-serving members who experience these health conditions have access to high-quality care.
114. The Royal Commission has seen substantial evidence that some individuals have been unable to access necessary treatment through Defence or DVA, a theme we explore throughout the nine chapters in this part. This must be addressed as a priority.
115. We have also heard from individuals who were initially treatment resistant, but who went on to benefit from the use of alternative or novel therapies.¹²⁰ Despite the promise of these treatments, we have also heard of the difficulty that some have faced in accessing them.¹²¹
116. Defence and DVA should explore the potential benefits of alternative or novel therapies as a priority, including to manage or treat the conditions outlined above. They should also explore the barriers that serving and ex-serving members face in accessing these therapies. We note that this issue has also been raised by previous reviews.¹²²

117. More broadly, it is important that Defence and DVA take a proactive and open approach to treatment. Their priority should be to respond to and manage conditions that serving and ex-serving members experience. Where feasible, approaches to treatment should align across Defence and DVA.

14.3 Providing health care to serving and ex-serving members: an overview

118. In this section, we provide an overview of how health care is provided to serving and ex-serving members. There are several complex systems that have developed over time – something that can affect the quality of, and access to, health care.

14.3.1 One system for serving members, another for ex-serving members

119. Who is responsible for delivering health care and how a person accesses it depends on whether they are a serving or ex-serving ADF member.
120. The Australian Government is required by legislation to provide ADF members with clinically necessary medical, dental and other forms of health care that are required for them to be fit to perform their duties.¹²³ The scope of health care to which an ADF member is entitled depends on their service category.
121. Services for serving members are provided through health centres located on Defence bases throughout Australia. If an ADF member requires specialist health care that cannot be provided on-base, they are able to access a range of healthcare facilities and providers off-base. Defence also funds hospital care for serving members, with the exception of some services, such as elective plastic surgery.
122. Following separation from permanent ADF service, ex-serving members are no longer able to access the Defence healthcare system. Those who transfer to the reserves may retain some access.¹²⁴
123. Instead, ex-serving members must access health care through Australia's civilian healthcare system. This system is complex: a 'multifaceted web of public and private providers, settings, participants and supporting mechanisms'.¹²⁵ This can prove challenging for people who are not familiar with the system, an issue we explore in Chapter 18, Health care for ex-serving members.
124. Depending on their circumstances – for instance, if they have service-related injuries or illness – ex-serving members may be able to access DVA-funded health care from mainstream providers. To do so, they must go through the claims process described in Chapter 26, Supporting DVA claimants and clients. DVA also funds (and sometimes manages) rehabilitation services to support eligible ex-serving members with service-related injuries or illnesses.

125. DVA provides all ex-serving members who have served at least one day of continuous full-time service, as well as some reservists, with access to free non-liability mental health treatment and care (from mainstream providers), regardless of whether their conditions were caused by service.
126. In addition, DVA operates Open Arms, a free counselling and mental health support service that is available to serving ADF members, ex-serving members, and their families. This is discussed in Chapter 19, Open Arms.

14.3.2 The evolution of healthcare provision

127. The current healthcare model contrasts markedly to what was offered through the former repatriation hospital system, which traces its origins to World War I. At that time, general hospitals were established throughout Australia to treat wounded soldiers, particularly those who could no longer serve due to their injuries.
128. Those hospitals, which were managed from 1917 by the Repatriation Department, offered medical care and support to discharged soldiers who were injured during service.¹²⁶
129. In 1947, control of those hospitals transitioned to the Repatriation Commission under DVA.¹²⁷ New repatriation general hospitals were established, which became hubs for veteran health care, offering a range of services to serving and ex-serving members, including specialist medical care and rehabilitation.¹²⁸
130. In the 1980s and 1990s, however, repatriation hospitals were integrated into the mainstream hospital system, via the public system in some states and via the private sector in others.¹²⁹ This followed a review of the repatriation hospital system, which looked into perceived deficiencies in administration and use of resources, and considered how the needs of an ageing veteran population could be met. This process marked the end of the direct provision of health care by DVA (with the exception of Open Arms) and the beginning of DVA being a purchaser of care services.¹³⁰
131. As outlined in Chapter 18, some vestiges of the repatriation hospital system remain in the form of specialised health services for serving and ex-serving members. The Jamie Larcombe Centre in South Australia and the National Centre for Veterans' Healthcare at Concord Hospital in NSW are examples.
132. The end of DVA as a healthcare provider (with the exceptions mentioned) has had far-reaching, long-term consequences. We heard that the shift to being a purchaser of services led to the demise of a 'coordinated and managed system of care' based on 'the continuity of the clinical needs of the patients'.¹³¹ We also heard that it resulted in a hollowing-out of Australian medical specialisation in military and veteran health.¹³²

133. The Australian Government, however, expressed a different view. It told us that:

The divestment of the Repatriation Hospitals has actually seen an improvement in the continuity of care by allowing veterans to have greater access and choice of hospitals and medical specialists. It allowed veterans to create a continuous relationship with their local hospital and specialist, reducing the requirement to travel for treatment at the Repatriation Hospital, and maintain their quality of care, access to services and practitioners, over time, particularly as they were ageing.¹³³

Changes to Defence healthcare services

134. The Defence healthcare system has also undergone significant changes in recent years.

135. In 2008, Joint Health Command was formed to centralise responsibility for the delivery of health care in the garrison (on-base) environment and to simplify healthcare delivery.¹³⁴ Before this, health services were largely under the command of the single services (Navy, Army and Air Force).¹³⁵

136. Under past access arrangements, the range of services available and staffing levels varied depending on the geographical location of the base and the needs of the military units garrisoned there.¹³⁶

137. Since June 2012, Joint Health Command has outsourced the provision of Defence health services to third-party providers through the ADF Health Services Contract.¹³⁷ In 2019, the contract was awarded to Bupa Health Services.¹³⁸ Over 90% of clinical health services delivered to ADF members in the garrison environment are procured under this contract.¹³⁹ These changes, and their implications for members' experience of garrison health care, are discussed in Chapter 16, ADF healthcare services.

138. Defence established the Mental Health and Wellbeing Branch in 2023.¹⁴⁰ It is expected to be fully operational by January 2025.¹⁴¹ It will centralise a number of responsibilities related to mental health care and suicide prevention, including health promotion and protection activities, data collection, and the development of the joint strategy, as discussed in section 14.3.3.¹⁴² We consider this reform further in Chapter 15, Promoting health and wellbeing among ADF members.

14.3.3 Which documents guide the healthcare strategy?

139. Several strategies guide the delivery of health care for serving and ex-serving members.

140. The *ADF Health Strategy* provides the strategic direction for the provision of Defence healthcare services. It also supports the assessment of health-related programs in Defence.¹⁴³ We discuss the strategy in Chapter 16.

141. Defence and DVA are currently finalising the joint *Mental Health and Wellbeing Strategy 2024–2029*. As at May 2024, the strategy was in draft form; it is expected to be published in mid-2024.

142. Based on early drafts we have seen, the joint strategy will set out goals and outcomes for the short, medium and long terms. It will also establish a monitoring and evaluation framework.¹⁴⁴
143. The joint strategy was a response to the Productivity Commission's June 2019 report, *A Better Way to Support Veterans*.¹⁴⁵ It recommended that Defence and DVA undertake a new single strategy for veterans' lifetime mental health (their Recommendation 17.4).¹⁴⁶ The aim was to encourage a 'whole of life' approach to mental health and wellbeing, recognising the challenges posed by disconnected healthcare systems, among other things.¹⁴⁷
144. We discuss the joint strategy, including its limitations – as far as we have seen them in the draft form of the strategy – in Chapter 15.
145. Until the new strategy is finalised and published, Defence and DVA retain individual strategies related to mental health:
- The *Defence Mental Health and Wellbeing Strategy 2018–2023* sets out high-level 'objectives and [a] framework' around mental health and wellbeing outcomes, that underpin individual 'action plans'.¹⁴⁸
 - The *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020–2023* sets out how DVA supports the mental health and wellbeing of veterans and their families, including by embedding 'whole of life wellbeing'.¹⁴⁹

14.4 Cross-cutting issues that affect best-practice care

146. In this section, we discuss three 'cross-cutting' issues that can impact how health care is delivered: clinical governance, clinical expertise and cultural competency. We explore their impact on health care for serving and ex-serving members.

14.4.1 Clinical governance

147. The provision of good-quality, timely and effective health care depends on robust clinical governance frameworks.
148. Clinical governance refers to the set of relationships and responsibilities established by a health service organisation with relevant stakeholders – including management, workforce, patients and other healthcare organisations.¹⁵⁰ Good clinical governance is the means by which health services 'deliver safe and high-quality health care', 'continuously improve', and achieve 'good clinical outcomes'.¹⁵¹

Using existing models to strengthen clinical governance

149. The Australian Commission on Safety and Quality in Health Care developed its National Model Clinical Governance Framework in 2017 (the National Model).¹⁵² It was developed to support health services to implement safe and effective clinical governance systems that support safer and better care for patients and consumers.¹⁵³
150. While it only applies to health services in the acute sector at present, our view is that the framework is equally applicable for defence and veteran health care more broadly.¹⁵⁴ We also note that future work on the framework will explore clinical governance for primary care settings.¹⁵⁵
151. In Chapter 16 we explore clinical governance by looking at the key components of the National Model. These are outlined in Box 14.2, The National Model Clinical Governance Framework.
152. We identify opportunities for strengthening clinical governance in Defence's health services to ensure the provision of high-quality care and the establishment of a system that fosters collaboration between healthcare providers, including with acute and primary care services within a region, to deliver holistic and seamless care to serving and ex-serving ADF members.
153. Strong clinical governance is particularly important for ensuring that the workforce has the right qualifications, skills and training to provide safe, high-quality care to patients. It can also enable performance monitoring and quality improvement systems.
154. These issues can – and should – be improved within Defence and DVA. They are discussed further in this chapter and throughout Part 4, Governance and accountability.

Box 14.2 The National Model Clinical Governance Framework

The National Model has five key components:

(1) Governance, leadership and culture

Integrated corporate and clinical governance systems are established and used to improve the safety and quality of care.

(2) Patient safety and quality improvement systems

Safety and quality systems are integrated with governance processes to actively manage and improve safety and quality of care.

(3) Clinical performance and effectiveness

The workforce is deemed to have the right qualifications, skills and supervision to provide safe and quality care.

(4) Safe environment for the delivery of care

It is established that the environment promotes safe and quality care.

(5) Partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, management and evaluation.¹⁵⁶

Cultural enablers of clinical governance

155. In addition to the five points set out in the National Model, we would also like to see ‘cultural enablers’ introduced that support effective clinical governance.

A restorative just culture

156. Experts like Dr Kathryn Turner have stressed the importance of a ‘restorative just culture’ in health care.

157. The aim of a restorative and just culture is to create supportive environments in healthcare settings so that stakeholders feel safe to learn and improve care systems – even after a suicide has occurred.¹⁵⁷ It aims to supplant ‘pessimism’ around the ability to prevent suicides in healthcare settings, and to prevent the allocation of blame when suicides occur.¹⁵⁸

158. It recognises the effects of errors or adverse events on patients, families and healthcare professionals. It says that they can be ‘second victims’ after a suicide because they may experience feelings of self-blame, anxiety and guilt.¹⁵⁹

159. With this in mind, a restorative and just culture recognises the limits of punitive measures alone in preventing errors. Instead, it seeks to balance accountability with opportunities for education, training, counselling and rehabilitation.¹⁶⁰

160. It also encourages open communication, transparency and collaboration, and focuses on identifying underlying causes, applying corrective actions and sharing lessons learned.¹⁶¹

A healthy workplace culture

161. Dysfunctional work environments and unsupportive workplace cultures can have a real and lasting negative effect on health and wellbeing. This can affect the health of staff and their ability to carry out their roles effectively.¹⁶²

162. Research shows that workplaces can be harmful to health and wellbeing beyond harms caused by traumatic events. Issues of workplace culture include poor workload management, bullying, unsupportive leadership, feeling undervalued and insufficient time to rest and recover after a period of intensity.¹⁶³ Some of these issues are explored in more detail in Chapter 7, Culture and leadership.
163. These harms can be mitigated through effective, supportive leadership. We have heard how leaders can foster shared responsibility to create safe, productive environments and, in doing so, significantly increase workplace wellness.¹⁶⁴ They can do so by making sure processes are in place to prevent and minimise workplace hazards, including psychosocial hazards, and by modelling positive health behaviours.¹⁶⁵

14.4.2 Clinical expertise

164. Clinical expertise refers to a health professional's experience, education and clinical skills.¹⁶⁶
165. We have heard that having adequate levels of clinical expertise in the healthcare workforce supports better outcomes for serving and ex-serving members. For example, we heard that practitioners may need specialised training in the health conditions commonly experienced by serving and ex-serving members, including mental health conditions and musculoskeletal injury.¹⁶⁷
166. However, we have also heard that there has been loss of expertise in military and veteran health care since the divestment of repatriation hospitals and the 'civilianisation' of healthcare in ADF. This refers to the process by which non-combat ADF positions (such as clinicians working in the garrison environment) began to be filled by contractors and public servants who may have limited or no military experience.¹⁶⁸
167. Several witnesses have told us that this has affected the quality of physical and mental health care available to members.¹⁶⁹ This is not because individual medical officers are in any way negligent, but because the civilianisation of health care staff means they do not have lived experience of what it is like to be a serving member, and also because continuity of care may be affected.
168. We have also heard that a dilution of clinical expertise has meant there are fewer facilities to train new staff, meaning this loss of expertise becomes self-reinforcing.¹⁷⁰ Further, we heard how it has resulted in the breakdown of institutional connections and collaborations between military and veteran health care, and mainstream health settings.¹⁷¹
169. A lack of clinical expertise may also affect how agencies like DVA operate at an organisational level. For example, Professor Alexander (Sandy) McFarlane AO, Emeritus Professor of Psychiatry at the University of Adelaide, suggested that there has been a 'hollowing out' of specialist mental health expertise within DVA.¹⁷²

170. In a submission, Professor McFarlane gave his views on the impact of these arrangements:

As a consequence [of a lack of specialised expertise in DVA], much of the policy development and service delivery models are developed without specific professional, academic or clinical experience or knowledge.

Although this is a generalisation and there are exceptions, the lack of knowledge and experience of those working in these domains is significantly hampered because they are not developing services or service models based on a sophisticated and intricate knowledge of the international literature and standards of current practice.¹⁷³

171. He further argued that a 'lack of knowledge and experience' in DVA has reduced the effectiveness of DVA policy decisions and decreased the quality of care.¹⁷⁴ He said that a lack of qualified clinicians also impeded quality assurance processes.¹⁷⁵
172. Building expertise can take time, but it is essential. In subsequent chapters, we propose measures to augment specialist veterans' care and improve research relevant to the health of serving and ex-serving members. In Recommendation 62, we also propose that measures are taken to support the development of a research translation centre (RTC) for Defence and veteran health care, or a similar body, to promote research and embed knowledge across the healthcare sector.

14.4.3 Military cultural competency

173. The health care that serving and ex-serving members receive must be appropriate for their needs, which includes being culturally safe and culturally competent. This means that those who provide health care should recognise that they are working with clients from a culturally specific group. Healthcare staff must have empathy, kindness and an understanding of a member's experience to be able to interact with, communicate and work effectively with this community.¹⁷⁶
174. Cultural competency in the people who deliver health services is essential if they are to understand and respond to the health needs of serving and ex-serving members. This approach can enable more effective treatment and support.¹⁷⁷
175. The Royal Commission has heard extensive evidence about the importance of cultural competency in delivering health care to serving and ex-serving members.
176. A panel of medical experts with extensive experience in providing care for serving and ex-serving members gave evidence during one of our public hearings. The panel agreed that military cultural competency was a 'fundamental and critical matter'.¹⁷⁸ One told us that a lack of cultural competency 'poses a risk to the client'.¹⁷⁹

177. Panel member Associate Professor David Mitchell told us how this can underpin care:

You need to understand ... to walk in the shoes of a veteran or an ADF member, to some extent, to be able to understand their predicament, their context, to understand their language, to understand their vernacular, to understand their system, to understand the great tradition that exists within the military. And if you don't take steps to do that, then rapport is eroded, you cannot engage with the military member or the veteran.¹⁸⁰

178. Despite this, there is evidence that military cultural competency is not always present in the Australian healthcare system.

179. All garrison staff are required to complete training modules, including on military medicine and other aspects of military life.¹⁸¹ However, we have heard that 'contextual knowledge' is required to inform diagnosis and treatment.¹⁸²

180. Past reviews, including the Boss Report, highlighted the lack of military cultural competency in mainstream health settings.¹⁸³ In submissions to our inquiry, peak and professional bodies raised similar concerns.¹⁸⁴

181. Members told us how a lack of cultural competency impacted their healthcare experience. One submission said it was 'a fundamental problem impacting far too many veterans'.¹⁸⁵

182. We discuss issues around cultural competency and veterans' health care in Chapter 18, Health care for ex-serving members.

14.5 Building and sharing knowledge can lead to better health care

183. In this section, we discuss the importance of generating and sharing research. We explore what can be done in the field of Defence and veteran health. We conclude by recommending measures to develop a research translation centre or similar body, to advance this important work.

14.5.1 Research is important to health and health care

184. In Chapter 29, Use of data and research by Defence and DVA, we discuss the importance of good practices of collecting, analysing, sharing and reporting data, and conducting research that is timely and independent, as a crucial piece in the complex task of reducing Defence and veteran suicide.

185. Research findings are particularly important for improving outcomes in health and health care. As we have outlined, serving and ex-serving members often have health needs that differ from those of the broader population. They are more likely to experience certain conditions associated with increased suicide risk.

186. Good research can improve the shared understanding of how service affects people's physical and mental health. It can explore how particular conditions are linked to suicide and suicidality. Importantly, it can provide insights into the effectiveness of prevention, management and treatment.
187. In Chapter 29, we note the significant research program that Defence and DVA have produced in partnership with independent researchers, universities and other organisations. This has been central in building an understanding of the health needs of Australian serving and ex-serving members. Some of that research has been cited in this chapter.
188. We note, however, that the contribution and positive impact of this program of research, have been undermined by:
- the absence of clear, publicly available research work plans
 - concerns about the transparency of research (including the nature of their research priorities, programs and findings)
 - insufficient co-ordination of research and evaluation between Defence and DVA
 - a lack of lived experience voices shaping the research agenda.
189. We recommend ways to improve how research is managed and used, including through:
- the establishment of a new committee to guide research priorities and monitor outcomes
 - the creation of centralised research teams within Defence and DVA to improve research practice and help translate outcomes into actions
 - the publication of Defence and DVA research findings as a matter of course, rather than on a case-by-case basis
 - the publication of Defence and DVA research workplans.
190. We think these measures will improve how research into Defence and veteran suicide is managed and made usable, including as it relates to the health and health care of serving and ex-serving members.

14.5.2 Research can help address cross-cutting problems

191. Given the multitude of providers that support health care for serving and ex-serving members, it is important that different components of the system can generate and share information on their care.

192. Doing so can:

- build clinical expertise across the workforce
- leverage and share what is already known
- support a more culturally competent health workforce network
- ensure best practice is embedded
- break down siloes and elevate the status of research.

Building clinical expertise

193. As a first step, it is important that steps be taken to ensure that research informs practice, and practice informs research.

194. We have heard from witnesses that this can support meaningful improvements to health care for serving and ex-serving members.

195. Dr Jonathan Lane is a serving member and Senior Lecturer in Psychiatry at the University of Tasmania. He also works with DVA. Dr Lane developed the Group Emotional and Relationship Skills (GEARS) program, which helps serving and ex-serving members improve their skills in emotional regulation, interpersonal communication and relationships.¹⁸⁶

196. Dr Lane shared his experience that led to the development of the GEARS program:

the problem as a clinician is a lot of our work is influenced by research, but ... does the tail wag the dog or does the dog wag the tail? Research informs clinical practice, but clinical [practice] also informs what research needs to be done ...

[A]s a clinician, the clinical practice guidelines were telling me I should be doing this, this and this, but from a clinical perspective, I was having people come through my door and what they were doing wasn't working very well for them. Then, from the veteran and first-responder patients I had, what they wanted wasn't necessarily what we were being told to do either.¹⁸⁷

197. Dr Lane also spoke to the barriers he faced in doing this work, including living in a regional area with limited health resources and few clinicians.¹⁸⁸ To overcome these barriers and pursue his research, Dr Lane undertook a PhD.

198. Dr Lane's experience demonstrates the benefits of researchers and clinicians working together. Previous reviews have noted how the former repatriation hospitals used to support this relationship. According to the Boss Report: 'DVA's historical predecessor, the Repatriation Department ... allowed medical practitioners to focus on and develop expertise in the areas of most relevance to veteran health'.¹⁸⁹

199. The end of the repatriation hospital system, however, has meant that these institutional links no longer exist. It has taken away the setting and the means by which clinical expertise was – very effectively – developed and tested. It is critical that new systems are designed to replace this.

Leveraging existing knowledge

200. As we have noted, Australia retains some ‘specialised’ health services that focus on serving and ex-serving members. These are discussed in more detail in Chapter 18.
201. These services comprise a tiny fraction of Australia’s healthcare system; however, despite their small size, previous reviews, including the Boss Report, found that they retain crucial expertise in military and veteran health care.¹⁹⁰
202. It is important that the institutional knowledge these services offer is effectively leveraged, including through information sharing. This can help organisations to embed clinical expertise and support greater cultural competency across a bigger workforce.
203. However, fragmentation across the broader health system can make it more difficult for specialised services to build links with other providers.¹⁹¹ We explore this dynamic in more detail in Chapter 18.
204. Stakeholders in the mental health sector share this view. In their joint submission, Suicide Prevention Australia, Mental Health Australia and Relationships Australia called for efforts to ‘learn from, build on, and connect, what’s already working’.¹⁹²
205. They told us:

There are high quality, effective mainstream services that are working for veterans, defence personnel and their families. However, these pockets of excellence can be disconnected and under-resourced. Wherever possible we need to be leveraging what exists, by scaling up and connecting up what works, rather... [than] creating something new.¹⁹³

206. We agree with this sentiment. This, too, will require infrastructure that can overcome institutional barriers and bring providers together, so that the potential of these services can be realised. This is an objective of our proposal for the creation of ‘networks of care’, which we outline in Recommendation 72 in Chapter 18.

Collaborative research

207. There are also benefits that arise from pooling research and expertise more generally. In our view, bringing experts together to collaborate and integrating existing knowledge will benefit governments and health providers, as well as serving and ex-serving members. Doing so can not only improve the quality of research (which would benefit from better coordination and ‘network effects’) but also raise its status and profile. In turn, this could attract new researchers to the field, as well as additional funding.

208. Better coordination can also support the research community to speak with a single voice. This would increase the reach and impact of research findings and better allow them to inform real-world changes to policy and practice, including in clinical settings.

Helping to embed good practice

209. In Chapter 29, we outline the importance of ‘translating’ research. This means using research findings to inform programs, policies and practice, ensuring changes are sound, reasonable and evidence based.
210. We note that Defence and DVA have missed opportunities to use research to further the understanding of suicide and suicidality among serving and ex-serving members.¹⁹⁴
211. In Chapter 29, we suggest ways for Defence and DVA to improve their translation of research into policy. We recommend centralising responsibility for the research task, as well as other measures to increase its impact, including publishing most research by default.
212. In addition, we note the steps that DVA has taken to improve in this respect. For example, it has established a section that is responsible for translating research findings into policy, program and clinical practice improvements.¹⁹⁵ Additionally, in June 2024, DVA released a request for tender for the ‘Veteran and Family – Learning and Innovation Network of Knowledge (VF-LINK)’ program.¹⁹⁶ This involves developing research to support policy development and program delivery, and building DVA evaluation capacity, among other components.¹⁹⁷
213. However, further work is needed to enable research translation that supports optimal clinical and public health outcomes. In section 14.5.3, we recommend measures to leverage information, maximise its availability and improve access to it. The aim is to help ensure that research is better able to be translated into contemporary health care.
214. There is precedent for this in other fields of health research. In section 14.5.3, we outline existing efforts to translate health research, including through education, training and measures to make information more accessible for serving and ex-serving members, patients, clinicians and others.

14.5.3 The translation of health research should be a priority

215. Below, we explore the precedent to translate health research. We think that this should inform efforts to develop and promote research into Defence and veteran health care.

Research translation centres

216. Research translation centres (RTCs) provide an example of how to increase the impact and reach of health research by focusing on its translation.

217. RTCs are partnerships that are accredited by the National Health and Medical Research Council (NHMRC). They aim to expand and accelerate research translation to drive national-level change and benefit.
218. Each RTC is structured around a health or medical area of national significance. Examples include aged care and women's health. There are 11 existing RTCs and three 'emerging RTCs'.
219. Most RTCs involve partnerships between acute health services, community health services, primary care providers, research institutes, universities and government. Together, RTCs comprise the Australian Health Research Alliance, a collaboration of Australian health and medical research funders, research institutes and universities.
220. The Australian Health Research Alliance aims to address health challenges facing Australia by:
- facilitating and increasing the translation of research into policy and practice
 - promoting innovation
 - improving clinical practice
 - enhancing the research workforce
 - facilitating the integration of health care, health and medical research, and health professional education.
221. According to the Australian Health Research Alliance, RTCs play a unique role in Australia's healthcare system:
- Nationally, our centre partnerships include 367 hospitals, 28 universities, 53 medical research institutes, 33 First Nations community groups and primary care networks. This unmatched reach across health and research makes AHRA well-placed to deliver on Australian governments (National and State) ambitions to achieve better alignment between investment in research and health needs and priorities, and better health, social and economic outcomes from our health and medical innovation systems.¹⁹⁸
222. We believe that the RTC model would be an excellent way to support the translation of Defence and veteran health research, and increase its reach among health practitioners and across the broader health system.
223. An RTC slots into an existing and well-established framework. It offers known mechanisms that can support knowledge sharing between researchers and health practitioners, and the translation of research into clinical practice.
224. Accreditation through the NHMRC would also provide credibility and recognition that the collective was independently assessed. This would provide assurance for those relying on its outputs.

Features of a research translation centre

225. Analysis undertaken for this Royal Commission identified several key features across RTCs, including:

- a dedicated network of key partners in the relevant field
- a dedicated website, focusing on providing information and research to different target audiences
- information distribution networks
- the design and/or delivery of education and training to specific cohorts.

226. Based on these features, we consider what an RTC for Defence and veteran health research might involve.

227. Its network could include:

- researchers with expertise in Defence and veteran health
- staff from Defence and DVA, drawn from the new centralised research and evaluation teams we propose in Chapter 29, Use of data and research by Defence and DVA
- professional bodies such as the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists
- staff who work in veteran health
- relevant Primary Health Networks
- clinicians and other practitioners involved in the delivery of health care to serving and ex-serving members
- people with lived experience.

228. It could support the provision of education and training for:

- serving and ex-serving members
- garrison health staff
- clinicians and other practitioners in the mainstream health system.

229. It could have a dedicated website, with resources and topics including:

- information in plain English for serving and ex-serving members and their families and supporters regarding research findings on particular health conditions, including how to prevent, treat and manage them

- information for health service providers, including those offering primary health care, inpatient care, psychology services, and allied health services
- resources for experts and academics, including access to published research
- a repository of research, including research published by Defence and DVA.

Accreditation

230. According to NHMRC, a group of entities seeking accreditation as an RTC must be an 'established collaboration'. The collective must provide evidence of what it has already achieved, 'beyond the achievement of its individual partners'.¹⁹⁹

231. It must also demonstrate that it has met the following assessment criteria:

- (1) Evidence of translation of research findings into benefits for patients and the health care system.
- (2) Excellence in innovative biomedical, clinical, public health and health services research.
- (3) Organisational arrangements.
- (4) Strategy for achieving improved health and wellbeing of patients and the populations served, and improved health services.²⁰⁰

232. An RTC is accredited for a period of up to 5 years, during which time it is required to report its progress and impact to the NHMRC.²⁰¹ Accreditation rounds are timed to align with this period. The last call for submissions for accreditation closed in 2022. As of June 2024, there were no current opportunities to apply for accreditation.²⁰²

233. We recognise that the accreditation process poses barriers to the creation of an RTC specialising in translating health research for the benefit of serving and ex-serving members. Further capacity may be needed in order to meet some criteria, and this may take time. Accreditation would also need to align with NHMRC timelines.

A process towards better research translation

234. Even so, actions could be taken in the near term to support the better translation of research in Defence and veteran health. These could build on existing initiatives, such as DVA's VF-LINK program. Over time, they could support the eventual accreditation of an RTC, or the development of another body with a research translation focus.

235. In Recommendation 62, we recommend that the Australian Government fund initiatives to support researchers, clinical staff and others, including to develop the research base, undertake research translation, form partnerships and further develop training and education in the field of Defence and veteran health care.

236. Importantly, these initiatives are aligned with the NHMRC's accreditation criteria, and could support the eventual establishment of an RTC. Over the longer term, Defence and DVA should take further steps to this end, including supporting the development of governance arrangements and strategic documents.
237. This work should be undertaken in partnership with stakeholders in the research and health sectors. It should also be informed by the views of the committee proposed in Recommendation 117 in Chapter 29.

Recommendation 62: Establish a research translation centre for defence and veteran health care

The Australian Government should support the development of a research translation centre for Defence and veteran health care, or a similar body with an explicit research translation focus.

- (a) Defence and the Department of Veterans' Affairs (DVA) should work with relevant stakeholders, including researchers and health providers with expertise and experience in defence and veteran health care, to develop a model for the establishment of the research translation centre and priority initiatives for funding.
- (b) The model should be informed by the National Health and Medical Research Council criteria for accreditation of a research translation centre, and include the following aims:
 - (i) promoting and increasing research on Defence and veteran health care in Australia
 - (ii) translating research into improvements to the health system and better outcomes for patients
 - (iii) facilitating collaboration among and between researchers and clinicians
 - (iv) supporting research-infused education and training.
- (c) Defence and DVA should jointly develop a business case for the research translation centre for consideration by the Australian Government.

Endnotes

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15 Promoting health and wellbeing among ADF members

Summary

This chapter provides an overview of Defence's health promotion, prevention and early intervention activities related to the physical and mental health of serving members.

We explore the organisational stressors that impact mental health and wellbeing, and the role of leaders and managers in creating a context where positive behaviours, such as seeking help early, are fostered. We also comment on the new Mental Health and Wellbeing Branch that has been established to drive an enterprise-wide focus on mental health, wellbeing and suicide prevention.

Injury and illness not only cause pain and suffering for Australian Defence Force (ADF) members and their families; they also reduce the ADF's operational capability. Despite it being in the ADF's best interests to do everything it can to reduce the incidence and severity of injury and illness, we have found that this is not always the case.

On the one hand, the crisis of recruitment and retention has meant that commanders are under immense pressure to retain operational capability in the face of workforce shortages. This can lead them to make decisions that do not promote and protect the health of individual members, despite how they might personally wish to act.

On the other hand, real fears of medical downgrade, stigma around perceived weakness, a culture of stoicism and self-reliance, and other barriers to help seeking reduce opportunities for early intervention.

In this chapter, we explore how the ADF deals with injury prevention and how it fails to adequately address the causes and prevention of injury.

We identify gaps in the mental health screening of ADF members and shortfalls in the support Defence provides to members who have experienced a critical incident or potentially traumatic event.

We make recommendations that aim to:

- remove barriers to seeking help and reduce stigma
- improve injury surveillance and prevention strategies, so those injuries that cannot be prevented are identified, treated and rehabilitated early
- ensure that screening processes identify those needing additional support and/or who are at a heightened risk of suicide and that support is provided promptly.

15.1 Introduction

1. Defence operational capability relies on a fit and healthy defence force. To fulfil its core mandate, Defence must therefore enhance, protect and safeguard the physical and mental health of its workforce. Additionally, Defence has a duty of care and a moral obligation to do so, as one of the reciprocal promises that exist between the organisation and its members.
2. The Defence Corporate Plan states that ‘the mental health and wellbeing of our workforce is critical and we must maintain and promote a culture where people are supported’.¹ The then Chief of the Defence Force and service chiefs echoed this sentiment in evidence they provided to us.²
3. Despite these assurances, many serving members experience service-related injuries – physical and psychological. They come at a high cost to the individual and to the ADF, something we discuss in section 15.4. The burden of these injuries can be significant and long term for members and their families. Psychological and physical injury are risk factors for suicide and suicidality, as is medical separation from the ADF, which is often a result of injury.
4. In Chapter 14, Introduction to health care for members and veterans, we identified medical conditions that are prevalent among ADF members and associated with suicide and suicidality. The conditions we discussed in Chapter 14 are:
 - anxiety and depression
 - post-traumatic stress disorder (PTSD)
 - substance use disorder
 - chronic pain
 - brain injury
 - sleep disturbance
 - problematic anger
 - social isolation
 - moral injury.
5. Each of them has unique characteristics, associated risk factors and avenues for treatment. Our point is not that any one of these conditions ‘causes’ or is a sole contributing factor for suicide and suicidality, but that they often co-occur and affect people’s lives in ways that accumulate and compound.³ For example, physical ill health can be associated with later-onset mental health conditions, and chronic pain frequently exacerbates social isolation, sleep disturbance and problematic anger.⁴

6. As we discuss at length in Chapter 1, Understanding suicide, all people are exposed to both risk and protective factors associated with negative health outcomes (including suicide and suicidality). We must therefore be careful to understand these risk factors in context.
7. Indeed, one of the key messages of our final report is that risk and protective factors are all highly contextual. It would be misleading to pursue a linear strategy in the hope of it reducing the incidence of suicide and suicidality in serving and ex-serving members. A comprehensive and systemic approach is required. Our approach aims to:
 - prevent the occurrence of injury and ill health in the first place, as far as possible
 - foster and encourage a culture of positive health behaviours, such as seeking help
 - minimise the severity of health conditions by intervening early and treating them effectively
 - empower command to actively safeguard members' health and wellbeing, recognising that operational capability unequivocally relies on a physically and psychologically well workforce
 - improve screening mechanisms so that members at high risk can be identified and kept safe
 - identify, strengthen and increase members' access to a range of protective factors.
8. Initiatives across all these areas are of vital importance to suicide prevention.

15.1.1 Negative trajectories: injury to medical separation to a range of adverse outcomes

9. Defence and the Department of Veterans' Affairs' (DVA) Transition and Wellbeing Research Programme identified that members who experienced a service-related injury were more likely to medically separate.⁵
10. Medical separation as a risk factor for suicide has been identified in our own research and has also been observed by both the Australian Commission on Safety and Quality in Healthcare (ACSQHC) and the Australian Institute of Health and Welfare (AIHW). (We discuss it at length in Chapter 5, The military employment classification system and medical separation.)
11. In Chapter 1, Understanding suicide, we discuss our findings on the prevalence of defence and veteran suicide. Our research found that ex-serving males who served in the permanent forces and who separated involuntarily for medical reasons are 2.84 times (184%) more likely to die by suicide than Australian males.⁶
12. Ex-serving females who served in the permanent forces and separated involuntarily for medical reasons are almost five times (398%) more likely to die by suicide than Australian females.⁷

13. Being injured in the ADF can also affect how one is perceived by colleagues and command. Members have reported experiencing name calling, bullying, exclusion, ostracism and administrative violence, all of which can be highly detrimental to their mental health and literally add insult to injury.
14. In 2010, Defence commissioned the ADF Mental Health Prevalence and Wellbeing Study. Analysis undertaken to identify risks or suicidal thoughts and behaviours found a robust link between the existence of stigma, barriers to seeking care and the risk of non-lethal suicidality.⁸ Risk appears greater for those who perceive that they would be stigmatised for seeking help for stress, emotional or mental ill health or family reasons. Two findings stand out:
 - (1) If people believed they would be treated differently if they accessed help, they were 4.73 times more likely to make a suicide attempt.
 - (2) If people were concerned that they would be perceived as weak if they sought assistance, they were 3.93 times more likely to make a suicide attempt.⁹
15. These statistics are shocking and add a significant weight of evidence to the many accounts of serving and ex-serving members who have shared their stories with us. They told us in their own words how real the stigma is and how much of service life is coloured by military culture, despite the official position.
16. Dr Stephan Rudzki AM, a former Australian Army senior medical officer, explained the impact of stigma associated with illness and injury on ADF members:

If you fail to respond to treatment, you generally continue to have pain. And, unfortunately, if you get injured and then get better, that's okay, you've got your badge of honour, but if you don't get better, people start raising questions about your veracity and your credibility. You are often on prolonged restrictions [of what members can and can't do in their roles] and this can lead to questions about are you faking it. This leads to accusations of malingering, ostracism, mental distress, and then mental distress can lead to impulsive action.¹⁰
17. As we discuss in section 15.3.3, the real risk of being called a 'malingerer' – 'malingering' is still an offence under the *Defence Force Discipline Act 1982* (Cth) – even in 'jest', is a deterrent to seeking help. Submissions talked a lot about the negative effects of this label. One submission author wrote:

It took 6 months of not being able to move properly and not being able to sleep because of the pain before my MO [medical officer] took me seriously and admitted I wasn't just 'chit chasing' [wanting a medical certificate] to avoid field [training]. [I was] medically downgraded and had snide comments by [my] work team that I was not pulling my weight because I wasn't physically going field.¹¹
18. Lived experience witness Mr John Halloran recounted what happened to his son Tom, who was a serving member of the Army, was bullied as a result of having reduced duties due to a back injury, and died by suicide:

And he said, 'Well, basically, I was called a malingerer.' And he said, 'Dad, you don't know what that is, but basically, it's not a good idea to get called a malingerer. It is something that will hang around your neck for a long time.' He said, 'I'm doing less, and because I'm doing less, they think I'm not pulling my own weight, someone else has to pull my weight for me.'¹²

19. Because of the potentially devastating consequences of service-related injury, the importance of injury prevention and early intervention and treatment cannot be overstated.

15.1.2 What is Defence legally required to provide?

20. Defence's responsibilities to provide medical treatment to ADF members are explicitly set out in legislation.¹³ The *Defence Regulation 2016* (Cth) states that the Commonwealth is required to provide ADF members with clinically necessary medical, dental and other forms of healthcare that are required for them to be fit to perform their duties.¹⁴ Members' healthcare entitlements depend on their service category.
21. The *Work Health and Safety Act 2011* (Cth) (Work Health and Safety Act), which applies to Australian Government departments and agencies including the Australian Defence Force,¹⁵ imposes a primary duty of care on persons who conduct a business or undertaking to ensure a physically and psychologically safe and healthy workplace.¹⁶
22. In the context of the ADF, the 'persons' who conduct the undertaking are the Chief of the Defence Force and ADF officers.¹⁷ The Work Health and Safety Act is overseen and regulated by Comcare.¹⁸
23. The ADF is exempt from certain provisions in the Work Health and Safety Act.¹⁹ These include reporting 'notifiable incidents' during warlike and non-warlike deployments; the obligation to consult with workers, health and safety representatives and committees; and members' right to cease unsafe work.²⁰ These issues are discussed in Chapter 13, Oversight of Defence workplace health and safety.
24. Even with these justified exemptions, a weighty duty is placed on the ADF to ensure a physically and psychologically safe workplace. In the rest of the chapter, we make the case that in order to fulfil this duty, Defence needs to put more emphasis on:
 - promoting good physical and mental health
 - preventing injury and illness
 - creating and fostering a culture where help seeking is genuinely encouraged and never the cause of backlash in order to promote early intervention and treatment.

15.2 Snapshot of existing initiatives

25. Defence runs a range of programs and has various initiatives in place to promote health and wellbeing, prevent injury and illness, and intervene early. The key ones are summarised here.

15.2.1 The new Mental Health and Wellbeing Branch

26. In June 2022, the Secretary of Defence and the Chief of the Defence Force signed a directive to create a one-star position to develop and establish a Mental Health Awareness, Resilience and Suicide Prevention Branch. Now known as the Mental Health and Wellbeing Branch, the position is held by Brigadier Caitlin Langford who started in the role in November 2022.
27. The branch sits within the Defence People Group and is responsible for driving a whole-of-enterprise focus on mental health, wellbeing and suicide prevention. Its focus is on primary prevention, not clinical health service delivery, which remains the responsibility of Joint Health Command.
28. In May 2023, Brigadier Langford described the evolving purpose of the branch as ‘to direct, lead and inform the provision of mental, physical, social and spiritual policy, programs and assurance across the Defence enterprise to enhance the wellbeing of Defence people’.²¹
29. Further information on the branch is included in section 15.6.

15.2.2 Key plans and strategies

30. There are several plans and strategies that guide the delivery of health and wellbeing support across Defence.
31. Of particular relevance to this chapter is the ADF Health Strategy and the Mental Health and Wellbeing Strategy 2024–2029.

The ADF Health Strategy

32. The ADF Health Strategy, led by Joint Health Command, provides the strategic direction for health services across the ADF, and it guides resourcing decisions to ensure that the various activities align with its strategic objectives.²²
33. The strategy has two ‘lead pillars’, which are:
- force optimisation
 - operational health capability.²³

34. Supporting these lead pillars are a further five supporting pillars:
- trusted mission partner
 - smarter service delivery
 - a whole-of-life focus
 - health system insight
 - integration.²⁴
35. The current ADF Health Strategy was finalised in 2023 following a review of the 2021 version.²⁵
36. Among other things, the review recommended the development of ‘a single Defence Action Plan with clearly identified tasks, responsible officer, and timeframes’, as well as ‘measures and metrics against which performance ... can be assessed’.²⁶ These were recommended in response to feedback on the former strategy.²⁷
37. It appears that there is still a way to go in establishing an action plan and identifying clear metrics to measure the success of implementation.
38. In our final public hearing in March 2024, the Surgeon General of the ADF, Rear Admiral Sonya Bennett AM RAN, said this of the ADF Health Strategy:
- I look at it more as a strategic framework and would probably offer [that] the reason there have been no metrics is because they’re high-level strategic objectives that are hard to put metrics against.²⁸
39. Rear Admiral Bennett went on to note a number of concurrent activities taking place, including the finalisation of the National Defence Strategy, and the newly established Military Personnel Organisation (MPO), which sits within Defence People Group under the control of the Chief of Personnel. She said that her intent is:
- probably to propose a process – not an action plan per se, but a more fulsome planning process that aligns all of those planning structures under ... this strategic framework, but it’s almost like taking one step backward to go two steps forward, if you like, just so that – that all the planning that happens in Joint Health Command is aligned top to bottom and then that would be reported up through the Health Select Committee as well as to the MPO.²⁹
40. We agree with the need to align strategies and whole-of-enterprise efforts where relevant. However, we also emphasise the need for expediency, given the urgency of the issue. We make the same point when discussing the Mental Health and Wellbeing Strategy and the establishment of the Mental Health and Wellbeing Branch.

Mental Health and Wellbeing Strategy 2024–2029

41. Defence and DVA are working to develop a joint Mental Health and Wellbeing Strategy. As at May 2024, the strategy was in draft form and expected to be published in mid-2024.
42. Prior to this development, Defence and DVA had their own strategies related to mental health. They were:
 - the *Defence Mental Health and Wellbeing Strategy 2018–2023*, which set out high-level ‘objectives and framework’ around mental health and wellbeing outcomes that would underpin individual ‘action plans’³⁰
 - the *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020–2023*, which set out how DVA would support the mental health and wellbeing of veterans and their families, including by embedding ‘whole-of-life wellbeing’.³¹
43. The new joint *Mental Health and Wellbeing Strategy 2024–2029* (the Joint Strategy) aims to ‘reinforce a lifespan approach’ in line with the Productivity Commission’s recommendations in its 2019 report, *A Better Way to Support Veterans*.³²
44. A December 2023 consultation draft of the Joint Strategy articulated the following vision: ‘[That] Defence people, veterans, and families are empowered and supported to optimise mental health and wellbeing in service, throughout the journey into civil life, and beyond’.³³
45. The draft version stated five goals:
 - (1) Promote and assist wellbeing.
 - (2) Improve mental health and wellbeing through early intervention and prevention.
 - (3) Facilitate timely access to quality care and support.
 - (4) Use high quality evidence and data to drive positive outcomes.
 - (5) Grow a positive and connected Defence and veteran community.³⁴
46. These goals are intended to contribute to a series of outcomes in the short, medium and long terms within the strategy’s 5 years. We understand that the Joint Strategy will be underpinned by action plans setting out detailed actions and responsibilities and providing the structure for ongoing collaboration between Defence and DVA.
47. Noting that, until now, Defence and DVA have implemented separate strategies for the health and wellbeing of members and veterans, we recognise the development of a joint strategy as a positive step towards embedding a focus on lifetime wellbeing. This is particularly the case because the very siloing of and separation between Defence and DVA likely contributes to many negative experiences for transitioning members and ex-serving members.

48. While recognising that the draft of the Joint Strategy was not finalised at the time of writing, we make a number of observations intended to assist Defence and DVA in steering the strategy over its lifespan.

Is the Joint Strategy ambitious enough?

49. We have concerns about the ambition of the strategy. Based on our review of the draft, it appears that the Joint Strategy largely communicates examples of what Defence and DVA are already doing in relation to the stated goals, rather than stating a bold strategy with the power of inspiring and invigorating both organisations.
50. We believe this is what is needed and do not think the Joint Strategy goes far enough yet. As our inquiry has found, there are many opportunities to improve the situation for serving and ex-serving members and their families. Maintaining the status quo will not deliver the scale of the change required.
51. It may be that Defence and DVA are planning to include new actions that we have not yet seen. This would be appropriate. However, we note that neither Defence nor DVA Budget Portfolio Statements for 2024–25 included a funding commitment associated with the delivery of the Joint Strategy.³⁵
52. The Joint Strategy is supposed to be an overarching document that sets the strategic direction for mental health and wellbeing until 2029. It is therefore disappointing that the draft we have seen does not seem particularly future-focused or ambitious.

How will its impact be measured?

53. While we have questions about the level of ambition, we welcome the inclusion of goals and the articulation of short-, medium- and longer-term outcomes within the draft strategy. We also recognise the importance of establishing the Monitoring and Evaluation Framework, which the draft indicates will be released at the same time as the action plans.
54. It is critical to consider baseline data, targets and tangible measures to monitor and assess progress over the life of the strategy. They should inform the establishment of achievable goals and outcomes.
55. It is concerning that the draft Joint Strategy does not directly provide any tangible measures to enable change, outcomes and impact to be assessed over time. Outcomes need to be assessed to close the loop in translating aspirational targets into benefits for serving and ex-serving members.

56. To illustrate this, one of the medium-term outcomes in the draft is that 'Our People enjoy working in Defence'.³⁶ However, there is little indication of:

- what factors influence whether people 'enjoy working in Defence'
- how those factors might be addressed
- by what rationale they are linking workplace enjoyment and health and wellbeing outcomes
- how the goal is to be achieved within the 3-year period indicated
- how the outcome might be assessed or measured.

57. ADF Chief of Personnel, Lieutenant General Natasha Fox AO CSC, told us:

if you don't measure what you're doing, you don't know if it's working. We've measured a lot [of health and wellbeing measures] by access and even I measured a lot by participation and access, and I can take some of those as baseline measures now. But it's about the effect [on health and wellbeing outcomes] that we have to understand, and that is difficult, and that's where we probably need some support in terms of people who are much better at determining outcome measures, because everyone struggles with it.³⁷

58. We encourage Defence and DVA to ensure that specific baseline data, targets, and measures of impact are established so any measurable progress can be determined – and the strategy altered – if it is not found to be successful. In this way, the Defence community can actually see what is being done to improve health and wellbeing outcomes. The importance of transparency and accountability in terms of outcomes cannot be overstated.

The Joint Strategy has been a long time coming

59. It was back in June 2019, 5 years ago at the time of writing, that the Productivity Commission said a Joint Strategy to guide Defence and DVA in safeguarding the mental health and wellbeing of serving and ex-serving members was 'urgently needed'.³⁸

60. Despite this, as at March 2024, the consultation process on the draft Joint Strategy was ongoing, with the Director of the Defence Mental Health and Wellbeing Branch, Brigadier Caitlin Langford, suggesting it would likely not be finalised by the end of the 2023–24 financial year.³⁹

61. The then Chief of the Defence Force, General Angus Campbell AO DSC stated, in relation to the completion of the Joint Strategy, that:

It's slower than I would prefer. I want to emphasise that the realisation of a successful strategy needs the consultation aspect that it's currently undertaking to ensure it is a strategy that lands in a way that is embraced by the people who will apply it and is widely known by the wider community to whom it will benefit.⁴⁰

62. General Campbell added that the joint strategy is expected to be delivered 'as soon as possible', remarking:

I believe, in good faith, that we will see it completed by the middle of the year. And you are right to say, and I would say I would wish it sooner, but again like the [Mental Health and Wellbeing] branch, I want it to be as effective as it can be and so I have borne some delay to what I believe will be realisation of a much better product.⁴¹

63. We think it is possible to strike a balance between expediency and taking an evidence-informed approach. In our view, Defence and DVA have not achieved that balance. We would encourage both agencies to consider what could be done differently in the future to avoid delays.

Programs and initiatives

64. Defence as a whole enterprise, and the single services, offer a range of programs and initiatives to promote the health and wellbeing of members. This range is suitably and necessarily broad.
65. As was noted by the 2017 National Mental Health Commission's *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*, the range of services available to ADF members has improved since 2009, largely in response to the Dunt Review.⁴²
66. Defence has provided evidence to the Royal Commission confirming that its programs and initiatives are evidence-based and underpinned by academic research.⁴³
67. Annexure 15.1 at the end of this chapter provides a summary of Defence mental health and wellbeing programs and initiatives.

15.3 Minimising risks associated with ADF service

68. As we discuss throughout this report, the ADF is a unique workplace (or, rather, series of workplaces) with a culture influenced by high-intensity and high-stakes work.
69. In Chapters 3 to 7 in Part 2, *Serving the nation*, we discuss the inherent operational risks associated with ADF service. For example, service in the ADF can involve intense physical training, increasing the likelihood of musculoskeletal injuries, overuse injuries, and accidents. It often means frequent postings to different locations and regular time away from one's family.
70. Deployments to conflict zones may expose defence members to hazards such as improvised explosive devices and landmines. Combat situations and hostile environments elevate the risk of injuries arising from gunshot wounds, blast injuries and shrapnel wounds. It may involve witnessing incidents or carrying out duties that are inconsistent with one's moral code (discussed in Chapter 21, *Moral injury*).

71. Service can also entail exposure to hazardous materials, situations, and potentially traumatising events. Particular tasks, such as those undertaken by Navy clearance divers, also entail unique occupational risks and, despite safety protocols, carry inherent risks of accidents and injuries.
72. To manage these risks, Defence leaders must:
- train their workforce according to robust, evidence-informed protocols that minimise injury risk
 - always adhere to safety protocols
 - monitor injury rates and conduct injury surveillance and minimisation programs
 - provide access to quality medical care
 - offer ongoing support for Defence personnel's physical and mental wellbeing.
73. These measures are crucial for safeguarding defence members against the diverse array of physical and psychological risks they face during their service.
74. In addition to the unique operational risks associated with ADF service, there are day-to-day organisational stressors that can and should be eliminated to the greatest extent possible in order to prevent harm. These are discussed in the following section.

15.3.1 Organisational stressors impact mental health and wellbeing

75. In addition to the known risks associated with service life, members also experience day-to-day stressors associated with organisational life and risks that arise due to ADF culture and norms. These include bullying, harassment, interpersonal violence, administrative violence, abuse and misconduct (including sexual misconduct).
76. These behaviours persist despite the stated intentions of generations of senior leaders and many initiatives to improve organisational culture. As Professor Ben Wadham and colleagues wrote in a report we commissioned entitled *Mapping Service and Transition to Suicide and Suicidality*: 'Military institutional abuse is not simply interpersonal. It is a systematic, enduring institutional disposition.'⁴⁴
77. Exposure to behaviours such as these can ruin members' mental health. In some cases, it can be catastrophic to their immediate or long-term wellbeing.⁴⁵
78. Dr Jacqueline Drew of the Griffith Criminology Institute at Griffith University told the Royal Commission that there can be an overemphasis on trauma and critical incidents when looking at workforce wellbeing (in her context, of the police force). This limits leaders' capacity to proactively look at how to improve the wellbeing of their staff. Dr Drew said:

[W]hen we think about trauma and critical incidents, there is only so much our supervisors and leaders can do. They often feel helpless in what they can do to impact on the health of the officers that they lead. But ... [looking at organisational and operational systems] actually provides them with the opportunity to consider how their role, the organisation's role, in terms of policies and procedures, can be actually changed for the benefit. So it gives us an answer to a thorny problem if we are to expand our thinking to all of the things that are impacting on our officers.⁴⁶

79. Similarly, Professor Sharon Parker from the Centre for Transformative Work Design at Curtin University told the Royal Commission that it is often the day-to-day work that has a cumulative negative impact on people's mental health. When asked if it can be difficult for managers to understand or appreciate that work can have adverse effects on mental health, she replied:

Yes, it can. Sometimes I draw a little picture of an iceberg, and on the top of the iceberg I show various behaviours that people might engage in or they might experience stress, but underneath the iceberg the things that we can't see so clearly is the work, is the work design. And I use that metaphor to try and encourage managers to look under the iceberg and say, okay, somebody is experiencing stress, or they are not performing well, but why could that be? Let's look at the role of work. In psychology, there is a concept called the fundamental attribution error ... [which means] that humans have a natural tendency, when there are things going wrong, to blame the individual, rather than to look at the circumstances which the individual is within.⁴⁷

80. Operational tempo and its contribution to fatigue and potential burnout is another stressor associated with ADF service that can adversely affect health and wellbeing. One submission to the Royal Commission indicated that 'lack of proper fatigue management' contributed to their depression and anxiety and 'command objectives outweigh the health of personnel'.⁴⁸
81. Associate Professor Karina Jorritsma of Curtin University's Future of Work Institute has done research on the work of Navy submariners. Her studies have involved looking at the connection between work design (including rostering protocols and role clarity) and cumulative fatigue, recovery, emotional detachment, burnout and quality of sleep.⁴⁹
82. She told the Royal Commission that 'a submarine is an interesting [kind of] extreme environment', explaining:

It's one in which you have long deployments, continuous exposures to ongoing demands, you can't really swap people out or have spares and, in particular, here you've also got an environment in which you have no ... family contact for prolonged periods of time. And so there is this really interesting thing about limited respite recoveries, both from that scheduling and environmental conditions.⁵⁰

83. Interestingly, that study found that submariners' sense of job clarity and purpose was a protective factor in the face of those extremes:

[W]hat we see is it's actually the work environment and the structure of that work environment [that] is more predictive of their wellbeing outcomes than any of the type of individual appraisals, like family support for military life or any of those types of things that are often studied in this environment. So it goes back to the work and the work itself.⁵¹

84. The question is: how do we foster those protective factors and eliminate, or at least minimise, the risk factors?

85. The evidence before this Royal Commission confirms to us that difficult workplace environments – particularly where there is an unsupportive workplace culture – can have a real and lasting adverse impact on health and wellbeing.⁵²

86. Consistent with this, research by Dr Drew into the police force – which, on our assessment, is highly relevant to the Defence context – emphasises the considerable harm that can be caused to people by day-to-day organisational and operational stressors.⁵³ These include both individual psychosocial risks and organisational risks.

87. Individual psychosocial risks associated with work include:

- high job demands and low job control – where the role makes strong emotional and cognitive demands, but where the person has little control or autonomy in decision-making
- effort-reward imbalance – where the employee's perception and experience is that their effort is inadequately rewarded, financially and non-financially
- exposure to trauma – where there is regular exposure to traumatic events and/or potential threats as well as exposure to bullying or intimidatory behaviour
- job insecurity – where employees perceive their job as being insecure and themselves as being powerless to do anything about it.⁵⁴

88. Organisational risk factors include:

- low perceived organisational justice – in which the rules and social norms of the organisation related to the distribution of resources and benefits and the processes for governing decision-making are not deemed to be fair
- poor organisation culture or climate – in which employees perceive the policies, procedures and practices of the workplace, both formal and informal, to be negative in some way (for example, unsupportive, unfair, dangerous or punitive)
- lack of psychosocial safety – in which management's primary concern (reflected in their values, philosophy and priorities) is perceived as being the achievement of productivity goals at the possible expense of employees' mental health

- unsafe physical environment – in which the physical environment of the workplace, including exposure to noise, extreme temperatures or hazardous chemicals is dangerous or perceived to be dangerous
 - stigma – in which there is real or perceived judgement of certain behaviours, attitudes and actions, leading to negative repercussions.⁵⁵
89. Throughout our inquiry, we have heard evidence from many sources indicating the presence of all these risks within the ADF. In this chapter, and throughout the report, we argue that Defence is not doing enough to eliminate preventable risks. As a result, the previously good mental and physical health of members can be undermined, and pre-existing mental health issues exacerbated.
90. Professor Parker told the Royal Commission that it was the employers' moral and legal responsibility to think about the work people are doing and ensure that work does not cause harm.⁵⁶ She also said that good mental health among employees is often positive from a business perspective. In the Defence context, she said, this meant that 'good work design from a mental health perspective is also good from an operational perspective'.⁵⁷
91. Professor Parker outlined two strategies: the Thrive at Work framework and the SMART Work Design model.
92. The Thrive at Work framework was designed to shift perceptions of mental health so a workplace can take a more proactive, preventative, holistic approach to supporting mental health. The three pillars of the framework are:
- mitigate illness – 'yes, there are people in the workplace who are experiencing poor mental health and wellbeing, let's make sure we know about that, so let's be able to identify who those people are and let's make sure we can support those people'
 - prevent harm – 'let's make sure we design work so that it has the elements of work in it that are going to be psychologically healthy for people'
 - promote thriving – 'let's go even further and foster the wellbeing of people through creating great quality work'.⁵⁸
93. The SMART Work Design model was designed as a way to implement the Thrive at Work framework. The model fits within the 'prevent harm' pillar of the framework and consists of five components (the first letters of which form the acronym):
- stimulating – 'recognising that people want to have work where they've got a bit of variety, a bit of challenge, some meaning, some interest where they are growing and learning'
 - mastery – '[employees] need to have what we call role clarity ... and they need to have a sense of where does their job fit in the bigger picture of the organisation?'

- agency and/or autonomy – ‘this fundamental need that humans have, which is to be in control of their environment or to be able to shape their work’
 - relational – ‘when we go to work, we want to connect with other people, we want to be supported by our manager, by our peers, we want to have positive social relationships’
 - tolerable – ‘making sure that the expectations we have of workers, the things they need to do, are reasonable, and are something that they can cope with, and they don’t overwhelm their coping resources’.⁵⁹
94. While the language of these two strategies is more aligned with the civilian world, we think they might conceivably be adapted to the Defence context. Such an approach seems to us within the scope of the Mental Health and Wellbeing Branch, which is discussed in section 15.6.

15.3.2 Commanding officers need the capacity and capability to support health and wellbeing

95. As we discussed in Chapter 7, Culture and leadership, ADF leaders are accountable for setting and modelling organisational culture and for establishing a safe and respectful workplace environment.⁶⁰ As the then Chief of the Defence Force, General Campbell, told us: “command” inherently implies care for the people under your command.’⁶¹
96. In this section, we discuss the essential role that commanders play in establishing, modelling and sustaining ADF culture.

The role of commanding officers in supporting health and wellbeing

97. Commanders and managers have a duty of care for the wellbeing of members under their command or supervision.⁶² Commanders are also responsible for the outcomes of operations.⁶³ We acknowledge the stressful and demanding position commanders are in when trying to maintain operational readiness with a reduced workforce. From what we have seen and heard, we believe there are times when balancing these priorities creates a tension that is not often resolved in favour of individual members’ wellbeing.
98. In relation to health and wellbeing support, commanding officers play a gatekeeping role in that they have discretion in relation to:
- deciding when to request certain mental health screens⁶⁴
 - deciding whether or when to trigger ‘critical incident mental health support’⁶⁵
 - making referrals, including to rehabilitation programs⁶⁶
 - convening individual welfare boards⁶⁷
 - choosing to waive medical advice in relation to recommended workplace restrictions and when medical clearance has not been granted for a member to deploy.⁶⁸

99. It is therefore crucial that commanding officers be well supported to carry out their duties. They must possess the necessary information, skills and attributes to fulfil their obligations.
100. Defence can no longer afford to persist in the worldview that operational capability and member wellbeing are competing demands that must be resolved in favour of one or the other. This is not accurate and it is not in line with contemporary Australian values.
101. In the following section, we call on Defence to better support commanding officers so they are not forced to choose between the mission and their people.

Supporting commanders to fulfil their obligations

102. Defence has a range of programs, including training and guidance materials, in place to support commanding officers. Throughout our report, we identify areas where further support is required, and we make recommendations to fill these gaps.
103. These include:
- providing commanders with key data and metrics in a form that can be easily interpreted and actioned (Chapter 29, Use of data and research by Defence and DVA)
 - reforming performance appraisal processes so they include upward feedback (Chapter 7, Culture and leadership)
 - improving suicide prevention training, reflecting the additional responsibilities that commanding officers have (Chapter 17, ADF and DVA suicide prevention programs and initiatives)
 - specifically training commanders to assist with reducing stigma and removing barriers to seeking help (section 15.3.3)
 - changing protocols in relation to aftercare and postvention (Chapter 17 and Chapter 20, Postvention).
104. In addition, we wish to draw attention to the ‘Leadership for Wellness’ program, being piloted within the police, which could be a model for Defence to pursue in future. We think Defence could learn from work being done in other first responder workplaces, such as the police, which share some characteristics with the ADF.

The Leadership for Wellness pilot

105. Supporting leaders to model positive health behaviours is vital: it can inspire those under their command, foster shared responsibility to create safe, productive environments and significantly improve workplace climate.

106. This is reflected in the Defence Leadership Doctrine, which states:

It is not sufficient to just tell people you care for their well-being. You need to demonstrate it by your actions ... Being concerned for subordinates' domestic circumstances, living conditions and work environment shows that you care about them as people. Discussing personal ambitions and providing opportunities for personal development shows you care about them as professionals.⁶⁹

107. In her appearance before the Royal Commission, Dr Drew informed us of a Leadership for Wellness pilot program aimed at police middle managers. The program focuses on self-care, staff care, and enhancing awareness of impacts on health.⁷⁰

108. The pilot consists of a 5-day curriculum based on the principles of self-care and staff care. It is designed to increase the knowledge, skills and behavioural repertoire of managers to help them lead for positive wellness outcomes.⁷¹

109. The importance of such a project in the Defence context is clear. The culture of Defence is largely driven not by the upper echelons of the ADF but rather by middle-ranked commanders – who Dr Drew, speaking about the police context, described as ‘the meat in the sandwich’. She said:

They are trying to achieve organisational priorities, organisational objectives, and also try to manage the psychological health of their staff by not creating workplaces based on those priorities that are going to have a negative effect.⁷²

110. As she put it:

The advantage or the benefit of this model that I think is critically important when we are designing a program like we want to design for leading for wellness is to begin with the self-care of the leader [and] the need to not blame our leaders within our agency for all the problems that we're experiencing, particularly our middle managers ...

We often talk, in health and psychological research, about an analogy in the oxygen mask falling from the plane. We tell the parents to put their oxygen mask on first, look after themselves, and then, once they are okay, they are in the position to help ... [others]. That's what we want to start with and this model helps us do that ... [W]e cannot ask a leader to look after, be concerned and create a healthy workplace if we don't acknowledge their health first and understand their journey that may influence how they relate to the workplace.⁷³

111. The Leadership for Wellness pilot program is currently underway and is unlikely to be evaluated before the end of this Royal Commission. Nevertheless, we intuitively agree with the principles underpinning it and believe that Defence leaders at all levels need to model positive health and wellbeing behaviours. We strongly encourage Defence to monitor the outcomes of this program and consider whether something similar could be trialled in the ADF.

15.3.3 There are cultural and structural barriers to help seeking

112. Throughout our inquiry, we heard of a range of reasons why ADF members are reluctant to seek help for health conditions that may require treatment. Serving and ex-serving members told us about the negative consequences they experienced as a result of accessing healthcare.

Improve the health literacy of all serving members

113. Health literacy refers to ‘how people understand information about health and healthcare, and how they apply that information to their lives, use it to make decisions and act on it’. Health literacy has two dimensions:
- Individual health literacy is the skills, knowledge, motivation and capacity of a person to gain access to, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.
 - [The] health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system and affect the way that people gain access to understand, appraise and apply health-related information and services.⁷⁴
114. Low health literacy is linked to increased hospitalisations and emergency care presentations, less use of preventive services, difficulty interpreting health messages, poorer health status, higher mortality, and elevated healthcare costs.⁷⁵ It negatively affects health and disease self-management, and can lead to delayed diagnoses, more advanced illness presentations and poorer outcomes.⁷⁶ Both Defence and expert witnesses have given evidence endorsing programs to improve health literacy, and mental health literacy in particular.
115. In her witness statement, Lieutenant Colonel Nicole Walker, Commanding Officer of the Joint Health Unit – Central Australia, emphasised that among the ‘specific actions’ the ADF can take to reduce suicidality is to provide ‘[e]nhanced, meaningful and evaluated mental health literacy education across all levels of Defence’.⁷⁷
116. Lieutenant Colonel Walker said that ‘[i]ncreasing mental health literacy will assist ADF members to identify when they or their mates need to engage in strategies and focus on improving their own mental health and when to reach out for support from health professionals’.⁷⁸
117. The ADF Health Strategy identifies a need for increased use of data and better communication as two key enablers to support health literacy.⁷⁹

118. Health literacy was identified as particularly important for transitioning Defence members and their families to assist them in navigating a complex array of services and service providers. Mr Adam Monkhouse, South Australia's Acting Director of Health Services Programs, stated:

The health system is complex and requires a level of health literacy to be able to navigate it to understand the difference between public and private sectors, State Government, Federal Government. What does my Medicare card do? What does it get me? ... Do I need private health insurance? And that is something that veterans may be coming to, coming out of not having had to look into the private insurance market before or not having had a Medicare card before. Similarly, the transient nature of deployment and postings means that they may be in a capital city or in a regional area where they don't know the local services.⁸⁰

Cut through the culture of extreme self-sufficiency and encourage help seeking

119. ADF culture places significant value on sacrifice and self-sufficiency, as we discuss in Chapter 7, Culture and leadership.

120. ADF members' capacity to persevere through physical and psychological exhaustion and pain is an asset for war fighting.⁸¹ However, an adaptive capacity during a warlike deployment may become maladaptive once the member has returned home. The culture of extreme self-reliance can inhibit ADF members from asking for help and seeking appropriate treatment for conditions as they arise.⁸²

121. Professor Jane Pirkis, an expert in suicide prevention, told us:

Although you would think that being self-reliant is a good quality, and it definitely is in lots of circumstances, it does perhaps mean that if someone is not travelling so well, then they are less likely to reach out for help.⁸³

122. The Transition and Wellbeing Research Programme found that 82% of respondents who reported having mental health concerns at some point in their life but who had not received help for them said they 'would prefer to manage the problem on their own'.⁸⁴

123. We heard this first hand from members in their submissions to us. For example, a member told us of their experience of trying to 'push through' despite suffering mental health issues:

I tried to push through the problems by working harder, doing 12- to 14-hour days at work but still kept falling behind. The harder I pushed, the worse it got. The despair and inner loathing increased every day, and I felt I was falling into a dark hole from which I could never climb out of. I was fearful of seeking help because of the ramifications I knew would follow. I also refused to acknowledge or accept that I was suffering mental health issues in line with everything the Army had ever taught me. I was a Warrant Officer; 'This stuff does not happen to Warrant Officers, stop being a soft cock Linger [malingerer] and harden up.'⁸⁵

124. It concerns us that the culture that so emphatically values commitment to service and sacrifice can inadvertently act as a barrier to help-seeking behaviours.

Eliminate stigma around mental health and help seeking

125. We have heard about enduring judgemental attitudes towards serving members who require or seek help, those receiving mental health care and those undergoing rehabilitation for an injury.
126. Stigma is ‘the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency’ and it ‘can lead unfairly to discrimination against and exclusion of the individual’.⁸⁶
127. ‘Self-stigma’ occurs when people internalise negative attitudes and stereotypes about mental illness.⁸⁷ It often leads to feelings of shame and inadequacy, affecting a person’s ‘self-worth and confidence to seek help’.⁸⁸ People who experience self-stigma are less likely to engage with services.⁸⁹
128. A survey conducted by Roses in the Ocean, a national lived experience of suicide organisation, revealed members’ perceptions. They spoke of a ‘strong culture of don’t tell, of stigma, and don’t be vulnerable within the ADF’, saying ‘fear of career end or career pause is very real’.⁹⁰
129. Common experiences included being labelled a malingerer after seeking help; fearing being seen as weak; fearing a medical downgrade and its effects on deployability and remuneration; being bullied and harassed; being punished following disclosure; fearing the loss of one’s security clearance; and fearing letting down one’s unit.⁹¹
130. The combined effect of these very real concerns very often results in members avoiding treatment, which in turn contributes to worse physical health, chronic injuries and chronic pain.
131. Dr Nikki Jamieson, a lived experience witness and suicidologist, spoke of her son Daniel’s experience of being called a ‘malingerer’. She described it as ‘the worst possible form of threat somebody can put on another person’ in service.⁹²
132. We have also identified organisational structures and processes which themselves can be stigmatising. These include the military employment classification system (see Chapter 5, The military employment classification system and medical separation), the requirement for perpetual individual readiness, and promotion and deployment pathways that involve mental health assessments.⁹³
133. One member said they were dissuaded from seeking care for a back injury that led to muscle soreness, which got more serious over time: ‘This first visit I was told to be careful because back injuries can easily lead to a downgrade’.⁹⁴ The member went on to speak of the culture that prevented timely access to care:

Steering soldiers away from seeking further care should be the last thing occurring in these initial stages of treatment. Medical staff should be aiding their patients in their recuperation and recovery, not hindering their progress back to normal health. Many members have had mates downgraded, seemingly arbitrarily, on returning from the RAP [Regimental Aid Post]. These experiences, coupled with the behaviour of RAP staff, further perpetuates the stigma associated with presenting to the RAP. Instead of seeking early treatment to resolve minor issues, members hide their injuries and exacerbate their condition.⁹⁵

134. Stigma regarding suicide and suicide behaviours was also specifically raised by members. Anonymised witness BR2 said: 'I believe that in the ADF, if you utter anything about suicide, you are classified differently from the rest of the people.'⁹⁶ They went on to speak of the fear of being downgraded while at the 'peak of their career', and having their career development 'slowed down'.⁹⁷

135. There seems to be mixed opinion among Defence leaders as to whether there are organisational factors associated with stigma. Some say that new messages being broadcast about 'seeking help early' and ongoing cultural reform have led to an improved mental health culture in recent years.⁹⁸ Indeed, Brigadier Nicholas Foxall AM DSM said that there was 'no stigma whatsoever left attaching to mental health issues in 5th Battalion Royal Australian Regiment (5RAR)'.⁹⁹

136. However, other leaders have conceded that more needs to be done to deal with the issue of stigma. For example, Mr Greg Moriarty AO, Secretary of Defence, said:

I think that we could have done more and should have done more to deal with the issue of stigma. That leaders at all levels should have been very conscious of the reality of stigma, why our members didn't want to come forward or present as needing help.¹⁰⁰

137. He went on to say:

And there has been, I think, some real challenges for us in terms of dealing with stigma and making it really acceptable and, in fact, welcome for people to say 'I've got an issue here' and for our people to be able to better identify when somebody is struggling or has challenges. And I think that's something that we could have been looking at earlier. I believe, talking to people I've visited at bases and on units, it is now a more common part of the conversation, but the stigma of suicidality and suicide, [and] mental health more generally, is still a societal issue and we see it in our organisation.¹⁰¹

138. Mr Simon Marshall, an ex-serving ADF member, shared his views on the progress of reform in the ADF:

Defence is saying that it is changing and they put up their glossy posters and we have a mental health day where all go to the lecture room and we hear all about mental health issues, but the [runs] aren't on the board.¹⁰²

139. Given the importance of seeking help early to prevent medical issues from worsening and becoming chronic, we believe that Defence can and should do more to promote help seeking.
140. This should be achieved by first identifying and then removing all potential barriers – whether cultural or structural – that dissuade people from seeking help. ADF must also do more to reduce stigma associated with help seeking and managing mental and physical health conditions.

Recommendation 63: Reduce stigma and remove structural and cultural barriers to help seeking

The Australian Defence Force (ADF) should identify and remove cultural and structural barriers to help seeking and make a greater concerted effort to reduce stigma. This should include:

- (a) the Australian Government should remove reference to the word ‘malingering’ at Section 38 of the *Defence Force Discipline Act 1982* (Cth)
- (b) Defence should review all its policies and procedures and amend or remove those that are stigmatising
- (c) the ADF should develop a dedicated training program and a communications campaign to reduce stigma and promote help seeking.

15.4 Prevalence and type of injuries in the ADF

141. Many serving members are injured during their ADF career. According to Defence and DVA’s Transition and Wellbeing Research Programme, over two-thirds of current serving ADF members have had at least one service-related injury.¹⁰³ Approximately one in four ADF members reported having had two or more service-related injuries.¹⁰⁴
142. We acknowledge that some of the hazards of military service cannot be avoided, especially during wartime. However, we note that the majority of injuries in the ADF occur during physical training rather than on deployments.¹⁰⁵ Evidence provided to this Royal Commission indicated that over 60% of injuries experienced by Army personnel were from physical training, adventure and field training and sports.¹⁰⁶
143. Defence reported that 82,813 people were involved in work health and safety incidents in the 5 years between 2018–19 and 2022–23.¹⁰⁷

144. The breakdown of these incidents, as reported in the Department of Defence's *Annual Report 2018–19*, is:
- (a) 35 fatalities
 - (b) 977 serious injury/illness
 - (c) 2,011 dangerous incidents
 - (d) 45,272 minor injuries
 - (e) 15,302 near misses
 - (f) 20,496 exposures.¹⁰⁸
145. From other research, we know that the most common physical injuries experienced by ADF personnel are musculoskeletal injuries. This type of injury accounted for 58.6% of all injuries.¹⁰⁹ The next most common were fractures (27.9%), heat stress, exhaustion and dehydration (6.1%), effects of cold or exposure (2.2%), and burn injuries (2.0%).¹¹⁰
146. In addition to the risk of being physically injured, ADF members also risk experiencing psychosocial injury. We discuss psychosocial injury and Defence's obligations under the *Work Health and Safety Act 2011* (Cth) in detail in Chapter 13, Oversight of Defence workplace health and safety.
147. Defence defines psychosocial incidents as 'involv[ing] psychological factors and surrounding environmental impacts [that affect] a person's physical and mental wellness'.¹¹¹ These impacts may include exposure to bullying and harassment, for example, or work pressure, a traumatic event, the suicide or suspected suicide of a colleague, or a suicide attempt.¹¹²
148. In the first quarter of 2023, the main causes of psychosocial injuries reported across Defence were (in order of most prevalent) mental stress factors, work-related bullying or harassment, work pressure, and exposure to a traumatic event.¹¹³ In total, this represented a reported 67 psychosocial incidents across the ADF in that quarter.¹¹⁴
149. According to Defence's quarterly work health and safety (WHS) reporting, 40 to 60 psychosocial incidents have been reported every quarter since 2018.¹¹⁵
150. From the evidence we have seen, and based on our understanding of military culture, we believe that both physical and psychosocial injuries are likely to be under-reported. Barriers to reporting injuries are likely due to distrust of the medical system¹¹⁶ and fear of career implications and stigma associated with injury.¹¹⁷ Further, psychosocial injury is not always apparent and is not well understood. As such, we suggest that these numbers are not a true representation of the prevalence of injury.
151. Defence acknowledged the culture of reluctance to report injury and other WHS incidents in their Safety Behavioural Review:

Defence can only track its progress if it is confident in its data. The review has found that there is not a strong culture of reporting across the enterprise. Culturally there is a fear of recrimination for those who report incidents or near misses, and there is a lack of confidence that if reports are made, any constructive change will happen ... The primary reporting system, Sentinel, is not user friendly, and does little to alleviate the previous cultural concerns.¹¹⁸

152. This admission by Defence has been supported by experts. Professor Rodney Pope, Professor of Physiotherapy at Charles Sturt University and former Director of Defence's (now defunct) Defence Injury Prevention Program, told us:

So, we do know that what is being recorded in Sentinel is a vast underrepresentation of the injuries that [are] actually occurring in Defence. So that raises a few issues. I guess one of the key issues around Sentinel, the difference here, Sentinel is based on the individual themselves or their commander reporting the incident, and so they have to go to the trouble to find the form if an incident's occurred, to fill out that form and to submit that form.¹¹⁹

153. The long-term consequences of injury in the ADF can be dire. This point cannot be understated. Preventing the occurrence or injury and ill health in the first place, as far as possible, is vitally important. Defence must prioritise injury prevention and surveillance as a means to reducing medical separations and the risk that flows to suicide and suicidality.

15.5 Strategies for injury and illness prevention and early intervention

154. Injury is one of the single largest health burdens faced by military populations, including serving ADF members. The harm caused by service-related injuries is not confined to the physical but often manifests in psychological conditions and mental ill health.
155. Through hearing thousands of lived-experience accounts in submissions, private sessions and lived-experience witnesses, our inquiry has uncovered the scarcely imaginable toll that physical and psychosocial injury has had on ADF serving and ex-serving members.
156. This section describes why a focus on injury prevention and early intervention is so important. It identifies Defence's current policies and practices to address the injury burden and makes the case for overhauling the current approach to injury surveillance and injury prevention. It also calls for the radical improvement of processes around mental health screening.

15.5.1 Injury prevention efforts are uncoordinated and insufficient

157. As we have already discussed at length, many serving ADF members are injured in the course of their service and the impacts can be severe and wide ranging. While we note work underway by Defence to strengthen injury prevention and surveillance, overall we have observed shortfalls in ADF's approach to injury prevention. The evidence we have considered in forming our opinion that more needs to be done is described in the remainder of this section.
158. We understand the Defence Work Health and Safety area is responsible for managing and guiding the implementation of the Defence WHS Strategy. It provides enterprise-wide WHS products and services to minimise the incidence and severity of work-related injury, illness and disease.¹²⁰ This remit is broad and we believe that injury prevention requires more dedicated focus and expertise.
159. In June 2024, Defence told us that it established a 'Force Health Protection Directorate'.¹²¹ This directorate is within Joint Health Command and injury prevention is a priority area.¹²² This sounds promising, though we are unsure of the relationship between the Defence Work Health and Safety area, and the Mental Health and Wellbeing Branch (described in section 15.6).
160. We asked Defence to provide information on its current suite of injury prevention initiatives. What we heard was that its main injury prevention programs were overwhelmingly focused on conventional work health and safety issues such as electrical safety, ladder and manhole safety, hazardous exposures, maritime safety and equipment safety.¹²³ While these programs are important, they fail to directly address musculoskeletal injuries, by far the most common kind of injury for serving members.
161. Defence's 2020 Health Strategy outlined the ADF's plans for 'consolidation of injury prevention initiatives across the Services that ensures a unified approach and reduces duplication'.¹²⁴ When we asked Defence about their progress in relation to this plan, we were told that no one had been assigned roles or responsibilities for meeting the goals of the strategy.¹²⁵ Defence also told us that progress towards these goals is not being measured in any way.¹²⁶ We draw from this that no meaningful action had been taken to realise these aspirations.
162. Presumably as a way of rectifying this, in 2023, Defence told us that an action plan would be developed with measurable outcomes and roles and responsibilities assigned to each of the goals.¹²⁷
163. Since then, the 2020 version of the Health Strategy has been revised and the new iteration includes 'the optimisation of force readiness through increasing the overall health and performance of ADF members' as a strategic objective. Aligned to this, the desired 'end state' is a 'reduction in injury occurrence, severity, and impact'.¹²⁸

164. Defence cites the inclusion of this strategic objective as evidence that the ADF's injury prevention efforts are coordinated.¹²⁹ We disagree.
165. We did not find any evidence of a comprehensive enterprise-wide injury prevention and surveillance program. Instead, the services appear to have a patchwork of programs, which we summarise below.
166. Prior to 2020, Air Force had a single primary prevention program aimed at musculoskeletal injuries. However, by September 2023, this has grown to 26 programs across nine sites, covering personnel including fast jet crews, flight instructors and trainee aviators.¹³⁰ The benefits of these programs were explained to us as ensuring greater personnel welfare and enabling commanding officers to meet their obligations under the Work Health and Safety Act for both physical and cognitive hazards.¹³¹
167. Air Force also has a designated work stream within Headquarters Air Command called Human Performance Optimisation which, according to Defence, incorporates a sports science approach to injury prevention. We have heard that this is the preferred model for Defence to follow. As former Senior Medical Officer, Dr Stephan Rudzki, put it:
- the sporting model is a proven one and it's highly successful. I think contextualising it and perhaps adapting it to the specifics of military is the way to go ... exposing our physical training instructors to the way professional sports teams strengthen and condition their athletes gives them a benchmark.¹³²
168. In response to our queries, Defence also outlined programs run by Navy and Army. The Navy programs were focused on training at ADF dive schools and the assessment of clearance divers.
169. Concerningly, Army, which has the largest injury burden of the services, did not outline any specific programs to prevent or minimise musculoskeletal injuries within its workforce.¹³³ According to Defence, the current injury-prevention settings within Army for physical training are adequate. Defence told us:
- although not a program as such, it is valid to assert that the physical fitness entry standards that Army sets for recruiting pathways, the settings of the physical training (PT) programs and the skills of the physical training instructor (PTI) workforce combine to serve as injury prevention practices in the force-in-training and the trained force in Army.¹³⁴
170. We do not agree with Defence's claim.
- (1) Physical fitness entry standards are relaxed in certain circumstances and there is evidence that reducing physical entry standards does present risks to recruits' physical and mental health. We discuss this in detail in Chapter 3, Recruitment and initial training.
 - (2) From 2016, Defence has significantly increased its use of medical waivers, allowing certain candidates entry into the force despite failing to meet entry-level standards. Medical waivers have increased by 34% between 2016–17 and 2021–22.¹³⁵

Defence does not track the progress of waiver recipients and has no way of knowing whether they experience higher rates of injury, medical separation or other adverse outcomes.

171. We do not, therefore, find that physical entry standards alone are an adequate injury prevention measure, especially given the discretion afforded to them. Also, we did not see specific evidence of how physical training settings and instructor skill 'serve as injury prevention practices' in the Army. It is concerning to hear that this is Army's view.
172. Promisingly, we have been told that Army will be releasing its own Human Performance Optimisation Directive for 2024–2026 which will incorporate and institutionalise injury prevention across all of Army.¹³⁶ Additionally, Army is developing the Commanders' Guide to Psychosocial Hazards which aims to contextualise psychosocial risk in the Army and support commanders to reduce the incidence and severity of psychosocial hazards.¹³⁷ Both of these appear to be steps in the right direction.
173. We acknowledge the attempts by Defence to improve their injury prevention initiatives and programs. However, despite the recent improvements in the Air Force's approach to injury prevention and the Army's new Human Performance Optimisation directive, we believe that Defence can do much more than its current approach to injury prevention, particularly in its approach to injury data capture and surveillance.

The Defence Injury Prevention Program, while successful, was discontinued

174. We have heard evidence about an injury prevention program that the ADF discontinued despite it yielding positive results in preventing injuries.
175. The Defence Injury Prevention Program (DIPP) was implemented as a pilot program in the 1990s in response to the very high rates of injury and medical separation at the Army Recruit Training Centre at Kapooka.¹³⁸ It was found to be successful and, in 2000, was approved by the then Director General of Health Services for implementation across the entire ADF.
176. The DIPP formally began in 2003, managed by Defence Health Service Division and coordinated through the Directorate of Operational and Preventive Health.¹³⁹ The key elements of the DIPP were:
 - a focus on injury surveillance
 - in-depth analysis of injury surveillance data
 - use of data to support a structured training program for those implementing the program.¹⁴⁰
177. The DIPP followed a sports medicine approach to injury and was primarily focused on musculoskeletal injuries. It emphasised the development and implementation of a unit-level system for the prevention of injuries during ADF sport, physical training and other military training.¹⁴¹

178. The DIPP collected data via a point-of-care reporting system, which enabled it to measure rates of injury, time lost due to injury, and activity performed at the time of injury, in addition to any relevant environmental or other factors.¹⁴²
179. The training program developed as part of the DIPP was included in the tri-service training for physical training instructors at HMAS Cerberus and the aim was to incorporate it into other ADF trade training.¹⁴³
180. Evaluation of the DIPP found it successfully reduced injury rates by at least 30% and increased injury reporting.¹⁴⁴ Results also indicated an economic return of \$42 million for an outlay of \$3 million.¹⁴⁵ These savings were calculated based on direct medical costs associated with injuries, military rehabilitation and compensation costs, pension costs, and working days lost.¹⁴⁶
181. Despite its success, Defence stopped the DIPP sometime in 2006, citing wider ADF implementation as 'problematic':

Despite the soundness of the DIPP model, achieving wider ADF implementation and its full effectiveness will remain problematic unless and until major impediments to DIPP's wider implementation are resolved. These impediments relate mainly to insufficient resources, inadequate governance arrangements, and IT support systems poorly designed for DIPP.¹⁴⁷

182. Dr Rudzki explained the issues with the DIPP rollout in more detail, indicating that no one wanted to take ownership of the program due to the financial constraints in the ADF at that time. He told us:

Army saw its value but did not wish to fund it because they argued that it was a health activity and, therefore, it should be funded by Health. I sought funding from the relevant individual within the then Defence Health Organisation and was told that injuries primarily are an Army problem, not a Defence problem, so they declined to take the program on and continue its funding.¹⁴⁸

183. We asked Defence what happened to the DIPP and were told that its work had been absorbed by the three services as part of their 'business as usual'.¹⁴⁹ We do not believe this is the case. We have reviewed the information provided by Defence on their current injury data collection, management and reporting systems and their injury-prevention programs and do not see anything similar to what the DIPP was doing.
184. We are concerned that a program that demonstrated a significant reduction in injury rates was discontinued due to what appears to be a lack of organisational will. It is hard to understand, particularly as its fairly modest financial outlay was estimated to save around 14 times that amount. Furthermore, high injury rates are associated with chronic pain, poor mental health and medical separation, all of which are known risk factors for suicide and suicidality.
185. Preventing injury of serving members must be a priority for Defence.

ADF injury surveillance is inadequate

186. High-quality injury surveillance data and a fit-for-purpose system that easily allows for monitoring and reporting data and identifying trends are critical. Such surveillance can provide the evidence base to inform injury prevention strategies.

187. Defence itself, through the Defence Safety Behaviour Review, acknowledged the importance of data and identified challenges with its reporting system:

Defence can only track its progress if it is confident in its data. The review has found that there is not a strong culture of reporting across the enterprise ... The primary reporting system, Sentinel, is not user friendly, and does little to alleviate the previous cultural concerns.¹⁵⁰

188. The main two mechanisms for injury reporting are Defence's own Work Health and Safety Incident Report and reporting to Comcare of serious injuries and illness and dangerous incidents or fatalities (with the exception of those that occur during certain operations). This is a legal obligation under the *Work Health and Safety Act 2011* (Cth).¹⁵¹ We discuss Comcare and its oversight of Defence workplace health and safety in Chapter 13, Oversight of Defence workplace health and safety.

189. Sentinel is Defence's work health and safety incident reporting system. According to the Defence Safety Manual, it supports the management of work health and safety matters at a local level and allows users to escalate and inform senior managers of issues that require action.¹⁵² Sentinel allows for the collection and structuring of corporate work health and safety information for analysis and reporting; supports decision-makers at all levels; and assists individuals to meet their obligations under the Work Health and Safety Act.¹⁵³

190. Information collected by Sentinel is self-reported. Sentinel generates reports containing numbers of injuries over certain time periods, injury types, incident locations and the activity during which the injury occurred.

191. In response to our draft propositions, the Commonwealth agreed that 'even when injuries were recorded in the Sentinel system, it is ineffective for the purposes of injury surveillance and prevention'.¹⁵⁴

192. We also heard that Sentinel is not fit for purpose in other ways, too. Dr Rudzki, who was involved in the procurement process for the system, told us that the 'off-the-shelf' version did not collect sufficient specific data to enable injury prevention in a militarised setting. He said:

During the initial stage of the procurement process I attempted to get elements of DIPP incorporated into the system because it provides very generic, non-specific injury categories that are not actually beneficial for injury prevention, but there [were] far more APS (Australian Public Service) than ADF [making decisions] at that time, and the decision was made that we'll go commercial off the shelf ...

[I]t's really important to note that Sentinel was an off-the-shelf, civilian-based, civilian workplace system, that really was never intended to provide the level of granular information needed for proper military injury prevention.¹⁵⁵

193. Defence has also identified several limitations with Sentinel. When providing information to this Commission regarding injuries to ADF members during *ab initio* training, Defence noted:

The data has been harvested from Sentinel, and has the following limitations: Sentinel is a self-reporting system; injuries which occur during training which are not reported, are not otherwise able to be identified; Sentinel data is unable to identify smaller groups within the establishment level. For example, [it is] unable to exclude training staff from data of *ab initio* soldiers; free-text or selections of pre-determined lists can be left blank; the terminology or definitions present may present multiple options that fit the incident that occurred; data is collated at every site differently; and each site records information about training, injury and activity in a different way.¹⁵⁶

194. Additionally, Defence told us that:

Injuries captured in Sentinel are generally of an acute nature or when a specified incident can be attributed to the injury (i.e. a PT session). The dataset does not contain chronic or repetitive exposure type injuries; as a result, it is not possible to quantify mental health injuries.¹⁵⁷

195. That Sentinel cannot capture chronic, overuse or repetitive strain injuries is of concern to us, as is its inability to capture adequate information on psychosocial injury and harm.¹⁵⁸ To the extent that Sentinel does capture this information via a root cause field, there is evidence that individuals do not consistently complete this field.¹⁵⁹ We discuss this issue in detail in Chapter 13, Oversight of Defence workplace health and safety.

196. The Director of the Navy Clearance Diver's Trust, Ms Denise Goldsworthy AO, told us that repetitive exposure-type injuries were common among clearance divers but were often incurred during routine activities and could not be attributed to a single incident. She said:

You also have a lot of repeat exposures from some of the tasks, such as being on a high-speed boat that's going across the waves and every time the boat hits, you get a shock through the spine ... They do a lot of fast rope entry work, you know, coming out of helicopters ... So even if there isn't a specific accident that occurs, they are getting repeats of these types of injuries.¹⁶⁰

197. Professor Rob Orr, Co-Director of the Tactical Research Unit at Bond University and a former physical training instructor in the Army, explained that data can be misleading when only the 'main incident' that caused an injury is reported. He said that according to their research:

sport and physical training and combat training are the leading source of injury ... [O]ne of the things you have to understand is the 'why', however, and this is why risk management is so important. Because quite often the physical training and sport is the end point, is the 'yield point' [when the injury occurs]. It's the point where there is so much stress on the system that it decides to shatter ... You have got somebody passing out from heatstroke during a run in the sun, but they spent three hours on the parade ground beforehand, marching around, in the sun, on a black surface. So, yes, typically we see sport and physical training as the yield point, but that's because it's the most physically arduous component where the system is more likely to break.¹⁶¹

198. Professor Orr's evidence makes it clear that, in order to understand how and why injuries occur, context is essential, and this is precisely what Sentinel is not equipped to record.
199. Defence commissioned a review of Sentinel as its WHS incident recording system, which was undertaken by consultants Work Science in 2022 and reported to Defence in March 2023.¹⁶² The evaluation detailed a large number of changes that were required if Sentinel were to meet the desired WHS outcomes in the short and long term.¹⁶³ Issues raised that required improvement were user experience, taxonomy (classification of inputs), governance and data capture.¹⁶⁴ A roadmap was developed to address these shortfalls and Defence has begun to action them.
200. We understand that Sentinel is not intended to be an injury surveillance tool. It is therefore not set up to link data with the Defence eHealth System (DeHS).¹⁶⁵ According to Defence, the reason for this is that Sentinel only records workplace injuries and the Defence eHealth system is agnostic to how an injury or illness occurs. As such, a 'workplace nexus' is not required for the purposes of providing health care and/or rehabilitation.¹⁶⁶
201. Defence has also told us that there is no feedback loop between Joint Health Command and Sentinel, meaning that an injury reported in Sentinel is not a confirmed medical diagnosis of that injury, nor can it be.¹⁶⁷
202. We raise the point of linking data on workplace injuries with that in Defence's health system because data on service-related injury and illness is crucial to ex-serving members making DVA claims and seeking health care post-service.
203. Dr Rudzki emphasised that accurate injury reporting is essential not only for injury surveillance (and thus prevention), but also for the claims process post-service:

The importance of reporting injuries is beyond the injury prevention. I see a lot of veterans. I treat them. I often have to help them with their appeals to the Veterans' Review Board and the key stumbling block for so many of them is 'Yes, I hurt myself but it wasn't recorded' and DVA's rules of evidence for acceptability are quite strict: if there is no record of an injury in your service health injury, the injury never happened.¹⁶⁸

204. He also told us about patients of his who are former ADF members who regretted not reporting injuries, explaining:

so many of the patients I see regret the ‘Tough it out, don’t report it’, sort of issue and then one young Special Forces soldier I saw, who had 18 undiagnosed medical conditions tried to get them recognised prior to his discharge, and he was accused of lying by the doctor who he was seeing and he was furious about it and stormed out of the consultation ... [R]eporting has ramifications beyond simple injury prevention. It speaks to liability, it speaks to entitlement, it speaks to the provision of healthcare post-discharge. It’s really important.¹⁶⁹

205. Defence has told us about work underway to address the gap in injury surveillance:

The Defence/DVA Data Sharing and Analytics Solution (DSAS) will bring together data, including DeHS and Sentinel datasets, to produce a suite of analytical products that will provide a longitudinal insight into chronic and repetitive types of physical injuries. These products will help develop effective injury prevention and rehabilitation regimes further for ADF members in the future.¹⁷⁰

206. According to Defence, DSAS will commence operation from the end of 2024. However, it notes risks to this timeframe and to the final operating capability due to privacy and consent issues.¹⁷¹ This includes the sharing of information and data across systems and between Defence and DVA, with appropriate safeguards around consent.¹⁷² We encourage Defence and DVA to work together to identify options for removing unnecessary impediments to the sharing of information, including consideration of legislative amendments, while balancing members’ right to privacy.

Commanders and physical training instructors play a key role in injury prevention

207. Injury prevention requires leadership, a skilled workforce and a concerted effort to ensure that it is encouraged and supported. Professor Pope put it very simply: ‘... injury prevention in every unit is everybody’s business’.¹⁷³
208. We have heard many times the importance of leadership in implementing and sustaining initiatives to prevent injuries. Professor Pope explained that leaders can have a huge impact on rates of injury:

So that leadership is critical, and if we look at the literature on what makes the most difference to injury rates, they are two of the key things that we see are the training volume control, monitoring that, and the leadership aspect within units.¹⁷⁴

209. This is supported by recent research undertaken by the US Army Public Health Centre, which found that as confidence within commanders decreased, rates of injuries increased.¹⁷⁵

210. We accept that commanding officers juggle a number of priorities and are under a lot of time pressure. To enable them to act to reduce injuries, it is critical that they receive relevant information on injury rates and prevention strategies. This information must be timely and provided in a form that they can use. As Professor Orr said:

When it comes to command, we've got to be very cautious of time. They've got a whole bunch of other competing priorities and if we're going to give them [more] information, we have to be very cautious.¹⁷⁶

211. From what we heard, commanding officers do not routinely engage with injury data as part of their day-to-day activities. When asked, Wing Commander Martin Parker, Commanding Officer at RAAF Base Tindal, confirmed that he does not have data on the incidence of physical injuries.¹⁷⁷ He said, 'I haven't asked for that data from the medical professionals, and it's not something I've seen come across my desk passively.'¹⁷⁸
212. Counsel Assisting put to Brigadier Kahlil Fegan DSC, then Commander of the 3rd Combat Brigade, that the current system has a shortcoming insofar as it does not systematically monitor injury rates. The Brigadier said he concurred with this statement and said he found accessing injury data to be 'more challenging' than he thought he should have found it.¹⁷⁹
213. If, as we have heard, commanding officers do not have easy access to injury data, it reasonably follows that making them accountable for addressing injury rates within their units is difficult. This further supports our proposition that current injury data capture and surveillance is inadequate.
214. In addition to commanding officers, physical training instructors also play a crucial role in injury prevention. Given that the majority of injuries occur during physical training, it is important to have a skilled workforce which is capable of implementing evidence-based training practices and playing a leading role in injury prevention.
215. Physical training instructors are experts in training and should consider injury risk in the training schedules they develop. Professor Orr made the case for increasing the training requirements of physical training instructors. He said: 'We need to upskill the physical training instructors to include things like detailed anatomy, detailed biomechanics, and... we need to teach them motor control and motor learning.'¹⁸⁰
216. As we understand it, if physical training instructors want to undertake professional development, they have to take the initiative themselves, as there is no structure by which Defence offers it to them.¹⁸¹ As a result, physical training instructors who do seek professional development often find training programs that are popular or well-marketed at the time, rather than ones that would be more relevant and beneficial to their role.¹⁸²

217. From all the evidence we have heard, we do not think that Defence is adequately prioritising injury prevention. Further, we contend that their injury prevention and surveillance efforts are insufficient. Sentinel is not fit for recording injuries that occur during physical training, combat and field training. It is also not adequate for recording chronic or repetitive exposure-type injuries or psychological injuries.

Recommendation 64: Establish an enterprise-wide program to monitor and prevent physical and psychological injury

The Australian Defence Force should establish a comprehensive, enterprise-wide injury surveillance and prevention program. The program should encompass physical and psychosocial risks and hazards, and:

- (a) be adequately resourced, including by engaging staff with appropriate expertise in injury prevention, including physical and psychosocial injury and illness
- (b) identify the most common injury risks and hazards and implement strategies for preventing or minimising them
- (c) include functionality within the reporting system to identify root causes or contributing factors including location, time, and activity being undertaken at the time of injury
- (d) actively monitor where injuries and psychological risks and hazards occur and generate quarterly reports on injury rates and clusters with actionable recommendations for commanding officers.

15.5.2 Responding to critical incidents and potentially traumatic events

218. As we have described earlier in this chapter, exposure to trauma is one of many risks of service that can affect members' mental health and wellbeing.
219. We accept that exposure to trauma is an inherent risk associated with military service, and it can never be completely eliminated. However, it is possible to reduce the impacts of this exposure.

Critical Incident Mental Health Incident Support

220. Critical Incident Mental Health Support (CIMHS) is the ADF's framework for early intervention support for members who have been exposed to a critical incident or potentially traumatic event.¹⁸³ It is provided in order to 'maintain and/or improve the mental health and wellbeing of Defence personnel' who have been affected by the incident, as well as to 'assist commanders and managers to meet their duty of care obligations in accordance with [the] *Work Health and Safety Act 2011*'.¹⁸⁴

221. The terms 'critical incident' and 'potentially traumatic event' are defined by Defence as follows:

A critical incident is a psychologically distressing event which is outside the range of usual human experience, and which has the potential to easily overcome a person's normal ability to cope with stress. A potentially traumatic event usually involves a person having experienced, witnessed, or [been] confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.¹⁸⁵

222. In this section, we use the term 'critical incidents' to encompass both critical incidents and potentially traumatic events since the CIMHS response covers both and potentially traumatic events can also be considered critical incidents.

223. The Defence Health Manual states that a CIMHS should be requested by commanders and managers 'any time they believe that Defence personnel ... have been exposed to a critical incident or potentially traumatic event'.¹⁸⁶ CIMHS is mandatory in the context of a death or very serious injury.¹⁸⁷

224. A CIMHS request leads to engagement with a CIMHS coordinator who, in consultation with the commander or manager, decides whether a CIMHS should be implemented.¹⁸⁸

225. A CIMHS response may consist of a variety of interventions. It is described as a 'phased, flexible and scalable model'¹⁸⁹ that occurs in three phases:

- the planning and immediate response phase
- an initial psychological intervention
- a secondary psychological intervention.¹⁹⁰

226. It does not always involve mental health screening to determine the extent of the psychological distress of people exposed to the critical incident.¹⁹¹

227. However, when mental health screening is undertaken, the same screening tools as those of the Mental Health Screening Continuum (described in section 15.5.3) are used. This includes the Kessler Psychological Distress Scale (K10), PTSD Checklist (PCL-C) and the Alcohol Use Disorders Identification Test (AUDIT).¹⁹²

228. The CIMHS policy as it stands was developed by the Australian Centre for Posttraumatic Mental Health (now Phoenix Australia) and adopted by Defence in 2002.¹⁹³

229. In 2008, Phoenix Australia produced a report evaluating the implementation of this policy.¹⁹⁴ This evaluation was described as the first phase of a three-phase program including:

- (a) phase 1 – validate the CIMHS model and its implementation
- (b) phase 2 – evaluate the impact on participants
- (c) phase 3 – modify training and/or other supporting documentation as required.¹⁹⁵

230. The report associated with the first phase concluded that the CIMHS policy was satisfactory but that its implementation over the following years would be critical.¹⁹⁶ The report highlighted the importance of 'ensuring clarity in understanding of the key principles, and consistency in the operationalisation of the flexible model'.¹⁹⁷
231. As we were told in 2023, in the 15 years since the 2008 report, Defence had not implemented either Phase 2 or Phase 3.¹⁹⁸ Defence has confirmed to us that there has been no evaluation of CIMHS outcomes for participants, including whether the model improves their mental health outcomes.¹⁹⁹ This is concerning.
232. In 2022, Joint Health Command conducted its own review of the CIMHS policy. The review recognised that critical incidents and potentially traumatic events will continue to happen in the military environment and a risk of psychological injury remains when members are exposed to critical incidents.²⁰⁰
233. The review found the process described in the CIMHS policy as adequate and recommended only a few minor changes.²⁰¹ These recommendations included:
- the development of a Commanders' Guide to Psychological First Aid to assist with the delivery of command-led activities²⁰²
 - that CIMHS screens only be conducted by professionals registered with the Australian Health Practitioner Regulation Agency.²⁰³
234. The review acknowledged that two major workforce changes occurred at the time of the review, including the cessation of the psychological examiner trade (a role that worked with psychologists and provided screening and administrative support) and the disbandment of the unit psychologists (1 Psych Unit) who had previously been responsible for organising CIMHS responses on deployment.²⁰⁴ These workforce changes are discussed in more detail in Chapter 16, ADF healthcare services. The review stated that it had not been able to consider these changes as part of its assessment due to their recency.²⁰⁵
235. We also note that the Joint Health Command review did not comment on implementation nor did it evaluate effectiveness, despite the fact that Phases 2 and 3 associated with the 2008 report remained incomplete. Given the lack of rigorous evaluation of CIMHS, particularly in terms of its implementation and impact, we suggest that this should be prioritised for evaluation.
236. We note further deficiencies in Defence's approach to evaluation in Chapter 29, Use of data and research by Defence and DVA. In that chapter, we recommend the creation of centralised evaluation and research teams within Defence and DVA.
237. We are also concerned about testimony that suggests the translation of CIMHS policy into practice is sometimes lacking.²⁰⁶ For instance, we have received lived-experience submissions that suggest the support and follow-up provided following critical incidents does not always meet the needs of the people affected.

238. One witness made a statement about their experience of the rescue operation following the tragic Taipan helicopter crash in July 2023 during Exercise Talisman Sabre.²⁰⁷ The witness reported the rescue team was not provided with proactive psychological support. Instead, individuals were required to self-refer to get any form of psychological support. The witness also expressed disappointment at there being no ritual of closure or service to mark the end of the recovery operation, nor was there any offer of post-operational psychological screening or a critical incident debrief.
239. In a separate submission, we heard about one member's experience following a life-threatening critical incident that occurred at sea. The member told us that 'support finally arrived, 5 days after arriving in port after several members had started to complain'. According to this member, the only debriefing occurred in a group setting and members had to self-identify if they wanted further help: 'Now in submarines it is a very close community and no one would want to display "weakness" in front of everyone. No one appealed for help during these debriefs.'²⁰⁸
240. A further submission recounted a lack of support following a critical incident that occurred during a deployment. They said:
- During my post-op psych review I burst into tears when I recounted what happened. I was met with a very cold response telling me I needed to have follow-up care. I refused. I developed mistrust in Defence's psychologists after having no support from them while I was deployed. If they didn't help me over there, why would they help me now?²⁰⁹
241. Negative individual experiences of CIMHS responses may be due to a lack of understanding and training of commanders on whom the CIMHS response depends. Other factors, such as the availability of services and supports in a remote location and operational tempo, are also likely to play a part.
242. According to the Defence Health Manual, when a critical incident has not resulted in death or a serious injury, commanders and managers use their judgement to determine whether or not affected members are to undergo a mental health screen.²¹⁰ They are responsible 'in consultation with critical incident mental health support coordinators, for facilitating delivery of critical incident mental health support services'.²¹¹
243. The Defence Health Manual further specifies that according to policy, commanders and managers must:
- (a) complete a Form AD675 when notified of any critical incident or potentially traumatic event involving Defence personnel
 - (b) reduce distress and attend to basic needs by providing information, support and practical assistance to personnel involved in a critical incident or potentially traumatic event
 - (c) consult with the critical incident mental health support coordinator about the appropriate level of response and support

- (d) identify those personnel who should be included in the response in consultation with the critical incident mental health support coordinator
- (e) complete work health and safety report on Sentinel for the event identifying all personnel affected by the incident
- (f) endorse and support critical incident mental health support activities and interventions.²¹²

244. However, the evidence we heard suggests there is a gap between policy and practice.

245. Consistent with this, the Australian Centre for Posttraumatic Mental Health in 2008 warned that analysis of the framework's effectiveness would rest on how it was implemented over time.²¹³

246. We consider exposure to potentially traumatic incidents to be one of the inherent risks of military service. It is, therefore, incumbent on Defence to have a best-practice framework for managing that risk, including that it is implemented as intended. Only by doing so can Defence minimise the long-term impacts on members' mental health and wellbeing brought about by critical incidents.

15.5.3 Detecting mental health issues early

247. This section looks at the way Defence identifies members who are at increased risk of adverse mental health outcomes by using a range of screening tools.

248. According to the *Defence Mental Health & Wellbeing Action Plan 2018–2023*, 'the primary advantage of mental health screening is to facilitate early intervention for treatment of mental health problems and disorders before they become entrenched and cause broader psychological problems'.²¹⁴

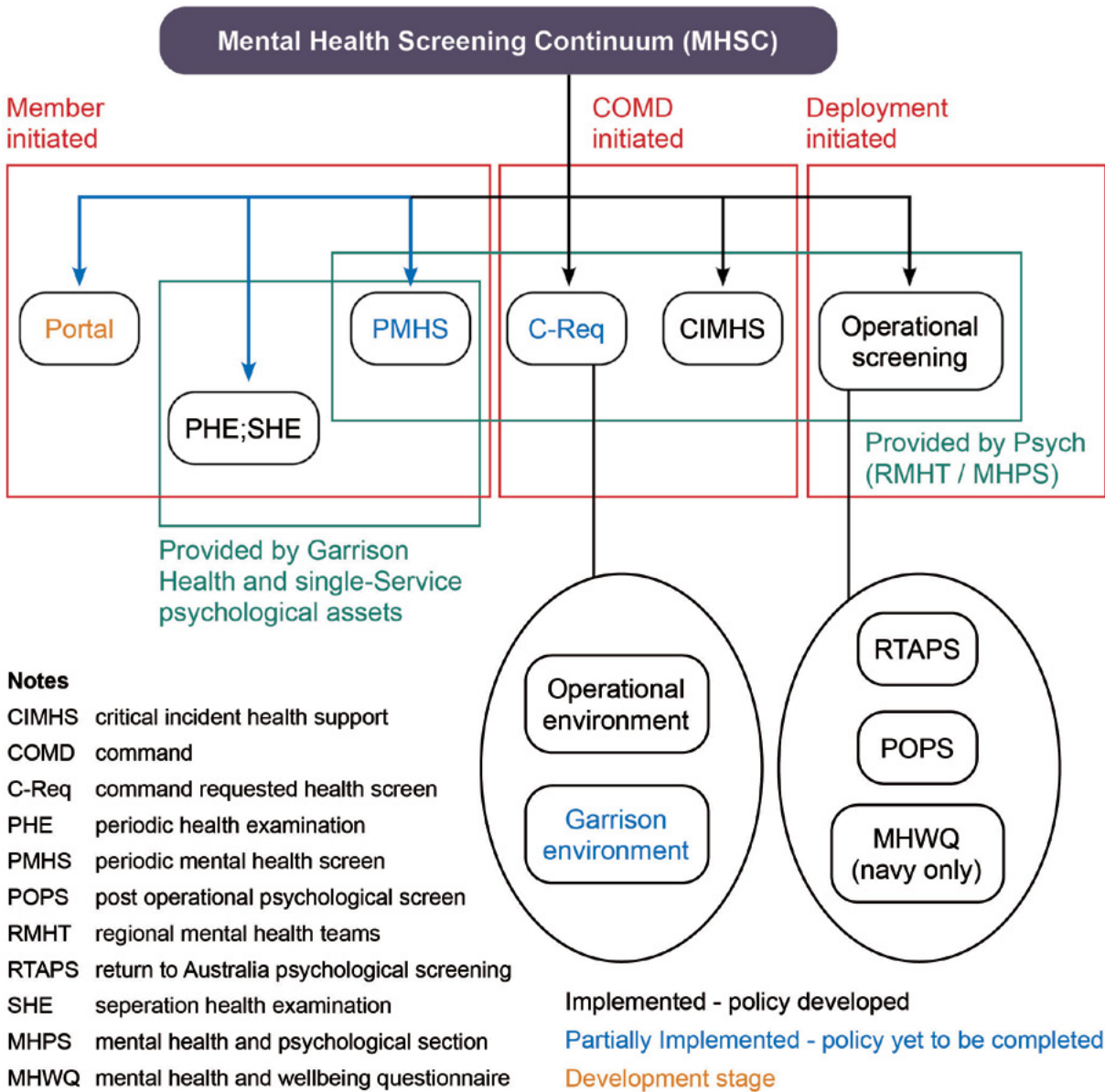
249. Like a number of previous reports and inquiries before us, we have identified a number of issues with ADF mental health screening processes. These issues specifically relate to how screening is administered and whether enough is being done to maximise opportunities for disclosure, whether there is appropriate follow-up and support once risk factors are identified, and the absence of screening at known points of vulnerability, such as initial training.

The mental health screening continuum

250. Screening for mental health issues is the primary mental health early intervention tool of the ADF. The ADF conceptualises its suite of mental health screens as a continuum, hence the title of this section. It has been designed to ensure that all ADF members are screened regularly as well as in response to specific events (such as deployment or return from deployment) and prior to separation. It aims to ensure that ADF members identified as being at higher risk can be referred for ongoing psychological and mental health support as clinically indicated.²¹⁵

251. Mental health screening involves using a series of tools – often interviews or questionnaires – to assess an individual’s mental health status. It thus identifies those at elevated risk of mental health issues or concerns.
252. When done properly, mental health screening should be a respectful, collaborative process in which the individual feels comfortable enough to provide honest responses. It should not be used as a diagnostic tool on its own but rather as an initial step in a broader and more holistic evaluation process.
253. In Figure 15.1, we show the different types of screening and how they fit together to form the mental health screening continuum. As the figure shows, some types of screening are member initiated, some are command initiated and some are initiated due to deployment. We discuss some of the different types of screening below.

Figure 15.1 The mental health screening continuum model



Source: Department of Defence²¹⁶

254. The ADF uses self-report questionnaires across its mental health screenings. These are generally comprised of:
- (a) Kessler Psychological Distress Scale (K10) – a measure of psychological distress based on symptoms of anxiety and depression;
 - (b) Post-traumatic Stress Disorder Checklist – Civilian (PCL-C) – a measure of PTSD symptoms; and
 - (c) Alcohol Use Disorders Identification Test (AUDIT) – a measure of harmful alcohol consumption.²¹⁷
255. These questionnaires are repeated across the screening continuum (as discussed later in this section) and produce numerical scores that can be compared at different moments in time and across various screening tools. This comparison of scores acts as a proxy for tracking a member's wellbeing over time.
256. Defence has told the Royal Commission that clinicians can review historical screens through the Defence electronic health system. Despite this, screening data is not presented in a way that would allow for a whole-of-population, longitudinal surveillance approach to the identification of mental health risk.²¹⁸

Deployment-related mental health screening

257. Being deployed on an operation increases the risk of certain hazards of service life. For this reason, Defence requires that deployed members undergo mandatory mental health screens in anticipation of returning home and also following their return home.
258. The ADF has conducted post-operational mental health screening since 1999. The key components of such screening, the Return to Australia Psychological Screen (RtAPS) and the Post-Operational Psychological Screen (POPS), have been conducted in their current format since 2003.²¹⁹
259. A RtAPS is provided to all ADF members who have been deployed outside of Australia and members should be screened immediately after they cease operational duties. The RtAPS is usually conducted during the last 7 days of a deployment in the area of operations.²²⁰ If it cannot be completed before the member departs the area of operations, it is to be completed within 7 days of their return to Australia.²²¹
260. The RtAPS measures psychological distress and post-traumatic stress symptoms and includes checklists of potentially traumatic and stressful events that members may have experienced on the deployment. The process includes:
- a psycho-educational brief (conducted as a group presentation and/or as part of the individual's screening interview)
 - the administration of the RtAPS questionnaire
 - a one-on-one interview with a mental health provider.²²²

261. For members who have deployed for fewer than 30 days (or as directed by a Health Support Order), a 'risk-indicated RtAPS' may be administered, particularly if the operation is considered 'within the moderate or higher range for psychological risk'.²²³ This includes operations where Defence is involved in disaster relief.²²⁴ The risk-indicated screen is an abbreviated version of the full RtAPS.²²⁵ Clinical judgement is then used to determine whether an individual should also be required to complete full post-operational screening.²²⁶
262. Within 3 to 6 months of their return to Australia, all members who receive an RtAPS undergo a POPS unless otherwise specified.²²⁷ The POPS includes the same mental health measures as the RtAPS, with the addition of a tool assessing alcohol usage (the AUDIT). The process includes the administration of the POPS questionnaire and a one-on-one interview with a mental health provider.²²⁸
263. Members who are redeploying fewer than 3 months after their return from a previous operation are not required to complete an RtAPS or POPS between deployments.²²⁹
264. Additionally, Navy administers the Mental Health and Wellbeing Questionnaire (MHWQ) to crews of mine warfare personnel, clearance divers, hydrographic surveyors, and meteorological and patrol force crews deployed on Operation Resolute.²³⁰ A 'risk-indicated' version of the questionnaire is administered to transient security element personnel on the operation.²³¹ Navy also offers the submariners' mental health and wellbeing questionnaire.²³²

Screening for non-deploying members

265. In 2014, Joint Health Command contracted Phoenix Australia, then the Australian Centre for Posttraumatic Mental Health, to develop an enhanced mental health screening program. This was in recognition of the fact that mental health screening had, to that point, largely focused on ensuring the wellbeing of deploying members and those who had been exposed to potentially traumatic events. However, it was acknowledged that ADF members who had not deployed were equally at risk of developing mental health issues.²³³
266. As a result, periodic mental health screening and the command-requested screen were added to the mental health screening continuum. The primary goal of the enhanced mental health screening continuum is to ensure that all ADF members are regularly screened regardless of their deployment status, with the aim of early identification and intervention for members who have symptoms of a mental health condition.²³⁴
267. Periodic mental health screening is a risk-indicated mental health screen that, according to Defence, occurs 'opportunistically', for instance, when a member attends a routine medical consultation and has not been screened or received mental health support in the previous 12 months.²³⁵ Following its implementation at seven health centres in 2018, periodic mental health screening was implemented across Garrison Health in 2019.²³⁶

268. Periodic mental health screening involves the electronic administration of the Kessler Psychological Distress Scale (K10), PTSD Checklist (PCL-C) and Alcohol Use Disorders Identification Test (AUDIT).²³⁷ If the member scores at or above the screening cut-off or if they wish to discuss mental health matters, the medical officer can conduct a further interview or arrange one with a mental health professional.²³⁸
269. Command-requested screens are for individuals and groups who are routinely exposed to intense and prolonged stressors in the course of their employment in both operational and non-operational environments.²³⁹
270. As the name suggests, they are administered at a commander's request and are intended to provide focused mental health promotion, identify emerging psychological problems and facilitate access to early treatment.²⁴⁰ A command-requested screen consists of a psycho-educational briefing followed by a screening questionnaire and an individual interview.²⁴¹

Issues identified with ADF mental health screening processes

271. The Royal Commission acknowledges that the screening tools used by the ADF have been developed in line with best practice. Defence uses standardised self-report screening tools, which have been shown to have good overall diagnostic accuracy in identifying mental health disorders.²⁴²
272. However, as previous reports and inquiries before us have found – and we have also observed – there are a number of issues with ADF mental health screening processes. These include that:
- regular screening with the same measurement tools means that members can learn the 'correct' responses and are thus able to avoid the detection of any mental health symptoms they have
 - form-based, tick-the-box approaches do not capture detailed information about an individual's circumstances and context
 - screening processes such as debriefs conducted in group settings discourage disclosure
 - some screens are not administered as mandated.²⁴³

Screens can be considered a 'tick-and-flick' exercise

273. The Royal Commission has heard, through lived-experience testimony and submissions, that screening is often considered a necessary annoyance to be completed as soon as possible. Paradoxically, the perception also exists that it is not worth disclosing symptoms as no extra support will be provided, or that disclosing symptoms will erode opportunities for deployment and promotion.

274. We heard, for instance:

[B]ecause the guys are on a deployment cycle you do the tick-and-flick. You want to get in and out nice and quick ... the guys knew they were going again and they don't want to knock back an operational deployment for a trip. So they are ticking and flicking, 'I'm fine, I'm fine, I'm fine.'²⁴⁴

275. One wrote in a submission: 'The ADF post-deployment psychology screening has become tokenism, in multiple [post-deployment screenings] I reported high anxiety and stress from deployment with no follow-up after care.'²⁴⁵

276. Another told us:

The military do conduct psych interviews during and post operational deployments, however I firmly believe these are paid lip service and 99% of members interviewed will not admit to any psychological issues because of the stigma associated with a mental health issue. I personally know if I had raised any issues during my interview at the end of the Afghanistan deployment, my promotion would have been cancelled. Again, if I raised issues during my post-deployment psychological interview it would have had a major impact on future postings and promotion.²⁴⁶

Risk factors are not always identified or acted on

277. In his 2009 review, Professor David Dunt noted that 'the main problem at present, though, is that it is quite unclear what happens to members who have mental health problems detected at RtAPS/POPS screens'.²⁴⁷ Defence told the Royal Commission that members who are identified via the mental health screening continuum as having mental health issues can be referred for further assessment and/or for mental health support.²⁴⁸

278. However, the Royal Commission has received submissions suggesting that there can be gaps in referral processes and limited or no follow-up. For example, one member told us:

I had the obligatory Post Operation Psych Screening (POPS) appointment in-country prior to RTA [Return to Australia]. I remember being clearly physically distressed and agitated during the session. I told the psychologist what I had experienced and he was stoic and said I would be fine. I don't recall having a follow-up psych appointment upon RTA.²⁴⁹

279. We also heard about delays in follow-up and inadequate support:

Despite filling in the Demounting forms indicating that I needed medical and psychological support, no communication of any form was forthcoming. I followed this up on multiple occasions [but] it was not until five months later that I was informed by the ADF that I had a doctor's appointment. I attended

the appointment only to be told that my injuries were not an ADF issue, but rather something that I should follow up with Department of Veterans' Affairs – despite my injuries occurring on the flood assist deployment.²⁵⁰

280. Another member spoke of the lack of follow-up: 'The POPS screening flagged issues requiring follow-up which ended after 6 sessions informing medical there were issues that need attention but there wasn't any follow-up on this.'²⁵¹

281. Asked whether Defence monitors members' attendance at referrals made as part of screening processes, Defence stated that it performs a regular 'case review process' to monitor treatment progress.²⁵²

282. However, Defence did not provide any detail as to when and how often this occurs, and what might happen if the member is not being well supported. We note that the Canadian Armed Forces, by contrast, stipulate in their post-deployment screening policy that:

Approximately 6 to 8 weeks after the interview, the appointment register is reviewed to assess whether recommended follow-up care was received. Those without such follow-up are contacted to determine whether further care is still needed.²⁵³

283. As for screenings not taking place as mandated, Defence material emphasises that it is the responsibility of individual members to ensure that operational mental health screening requirements (to take one example) are met.²⁵⁴ However, managers and commanders also have a role, as specified in the Defence Health Manual:

Managers and commanders have a particular responsibility to actively monitor the operational mental health screening obligations of Defence personnel. Managers and commanders must actively direct remediation of any failure by their Defence personnel to meet these obligations.²⁵⁵

The mental health screening continuum could be improved

284. Screening for mental health issues is integral to the ADF's efforts to intervene early when members have symptoms of mental ill health. We think there is an opportunity to improve mental health screening administered to ADF members.

285. Defence must ensure a sufficient and suitable workforce is available to administer screens and conduct the necessary follow-up. Submissions we received lament Defence's erasure of the 'psychological examiner' trade in 2021 and the subsequent loss of front-line mental health peer support.²⁵⁶ Psychological examiners supported the coordination of screening and related administrative tasks.²⁵⁷ They also provided technical and practical support to service delivery in garrison and on operations.²⁵⁸ We discuss the health and mental health workforce in Chapter 16, ADF healthcare services.

286. We also recommend that further consideration be given to ensure that all known points of vulnerability trigger a mental health screen. At present, screening is mostly triggered in relation to operational events and milestones. However, as mentioned throughout this report, risk factors for suicide and suicidality can be heightened in non-deployment situations such as during *ab initio* training.
287. As we discuss in detail in Chapter 3, Recruitment and initial training, there is no mandatory universal psychological or mental health screening of new recruits after enlistment.²⁵⁹ We think this should be rectified.
288. We also recommend that the screening be administered at other known points of vulnerability, including MEC downgrade and when accessing rehabilitation.
289. In addition, we recommend that other known risk factors for suicide be tested for in relevant screens where they are not already. These include problematic anger, sleeping difficulties and military sexual trauma, which we discuss elsewhere in this report.

Recommendation 65: Improve access to, timeliness and quality of mental health screening and use the data effectively

The Australian Defence Force should ensure that its mental health screening continuum effectively identifies members who require additional support and/or who are at heightened risk of suicide, and that these individuals receive support, by:

- (a) ensuring that members have access to screening and are offered referrals for further support at all known points of vulnerability, including: during *ab initio* training, when their military employment classification is downgraded, and accessing rehabilitation
- (b) ensuring that a sufficient and appropriately trained workforce is available to administer the mental health screening continuum and conduct the required follow-ups, including:
 - (i) ensuring screening is done in such a way that encourages disclosure, including face-to-face screening wherever possible
 - (ii) ensuring members receive timely and appropriate referrals following screenings where required
 - (iii) monitoring the uptake of referrals and following up with members who do not action these referrals
 - (iv) monitoring members who are overdue for screenings and following up with them
- (c) introducing tools that screen for known risk factors for suicide and suicidality that are not currently screened for, including problematic anger, sleeping difficulties and military sexual trauma
- (d) using the data collected during screenings for longitudinal surveillance.

15.6 An enterprise-wide focus on mental health, wellbeing and suicide prevention

290. As mentioned in section 15.2.1, Defence has established a Mental Health and Wellbeing Branch to enable an enterprise-wide focus on mental health, wellbeing and suicide prevention.
291. In June 2022, the Secretary of Defence and the then Chief of the Defence Force approved the creation of a one-star position in Defence People Group, to establish and lead the Mental Health Awareness, Resilience and Suicide Prevention Branch.²⁶⁰
292. The directive outlined that the branch will:
- (a) Strengthen the One Defence approach to mental health, resilience and suicide prevention for Defence personnel and their families;
 - (b) Enable alignment and interaction with the whole-of-Government approach, in turn reducing duplication across the enterprise and generating the greatest impact for Defence;
 - (c) Clarify roles and responsibilities for the strategic oversight of mental health, resilience and suicide prevention across Groups and Services, and in turn enable JHC [Joint Health Command] to optimise effectiveness in delivering a joint and multidisciplinary health approach to enable ADF capability and care for our people; and
 - (d) Reinforce Defence as an active leader in the workplace mental health reform and demonstrate a clear intent to continuously improve and build on the current work including embedding a focus on lifetime wellbeing of ADF personnel and their families.²⁶¹
293. This same directive outlined that once the new one-star position was filled, the incumbent would establish the required enterprise-level mental health and wellbeing functions over a 6-month period.²⁶² This timeframe was not achieved.

15.6.1 Progress to establish the branch has been slow

294. Brigadier Caitlin Langford began in the role of Director-General, Mental Health and Wellbeing Branch, in November 2022.²⁶³ In the evidence she gave in May 2023, Brigadier Langford said that the branch is expected to be fully operational by January 2025.²⁶⁴
295. This will be two-and-a-half years after the directive approving the branch's creation, and 3 years after private firm Protiviti undertook a review of Joint Health Command and identified several functions that could be transferred to 'a new branch' under Defence People Group.²⁶⁵

296. In our view, the time it took to set up the branch appears unnecessarily protracted, especially compared to the matter of months it took Defence to establish a taskforce to respond to this Royal Commission.²⁶⁶
297. Defence's enterprise response to the Defence Strategic Review was similarly swift, with Ms Justine Greig, Deputy Secretary of Defence People, indicating that this was partly enabled by prior work in 2021 and 2022 that had anticipated the reform.²⁶⁷ In making these comparisons, we suggest that a significant amount of prior work, analysis and information about suicide has also been long available to Defence and it could have resulted in a more timely establishment of the new branch.
298. While we recognise the importance of balancing expediency and the implementation of a quality product, the time Defence has taken to establish a fully functional Mental Health and Wellbeing Branch is simply incongruous with their stated prioritisation of health, wellbeing and suicide prevention.

15.6.2 Can the new branch influence outcomes across the whole enterprise?

299. We understand that one of the considerations of Defence for establishing the Mental Health and Wellbeing Branch within the People Group, rather than within Joint Health Command, was that Joint Health Command did not have the capacity to influence any wellbeing factors broader than its health remit.²⁶⁸
300. The 'wellbeing factors' referred to include:
- Health: Positive health contributes to an individual's ability to participate in and contribute to society.
 - Social support and connection: Relationships and community connections contribute to quality of life and enable positive health outcomes.
 - Education and skills: Education and training are essential to an individual's development [and] ability to lead a productive life, and enable positive life choices.
 - Employment: Stable and fulfilling employment, whether paid or unpaid, contributes to improved wellbeing.
 - Income and finance: Access to sufficient financial means is critical to overall wellbeing.
 - Justice and safety: Personal, physical and psychological safety whilst living in a fair and just community contributes to an individual's sense of overall wellbeing.
 - Respect and recognition: Community and organisational understanding, recognition and respect for the service of ADF members, ex-serving members and their families is a unique and important contributor to individual and community wellbeing.²⁶⁹

301. That list of factors is appropriately broad, and we agree that centralised responsibility for driving an enterprise-wide focus on wellbeing – as well as mental health and suicide prevention more specifically – is beneficial.
302. What remains to be seen, however, is whether the branch has the necessary capacity and capability to influence positive outcomes across the enterprise. We have been unable to form an opinion on this given that the branch is still in its infancy.
303. Rear Admiral Sarah Sharkey AM CSC RAN, then Commander of Joint Health Command, stated that the branch as a whole and the Director-General's position in particular will 'better enable all of the [wellbeing] factors to be addressed', with the 'focused leadership, coordination and attention' required to 'influence the mental health and wellbeing of ADF members'.²⁷⁰
304. Rear Admiral Sharkey also stated that the branch will enable Joint Health Command to 'strengthen and focus its resources towards optimising delivery of a joint and multidisciplinary health approach to ADF capability and care'.²⁷¹
305. We hope that this separation of responsibilities between the branch and Joint Health Command does increase focus on both health promotion and prevention, and clinical healthcare, by those best placed to fulfil such functions.
306. However, a key issue that arises is how to manage the interface between the Mental Health and Wellbeing Branch and Joint Health Command. This is particularly important given that the remit is suicide prevention and improved mental health for members. Due to the location of the new branch within Defence People Group, responsibilities for the clinical management of suicidality and suicide prevention are now separate.²⁷²
307. This means that, while the Commander of Joint Health Command is responsible for suicide management within the ADF, responsibilities for suicide prevention are now held within Defence People Group under the Mental Health and Wellbeing Branch.²⁷³
308. Similarly, Joint Health Command is responsible for the mental health screening continuum and Critical Incident Mental Health Support (CIMHS), which are key to Defence's prevention and early intervention efforts. We think these efforts would be well supported by the health promotion activities that fall under the branch's responsibility.
309. Governance mechanisms may facilitate integration if harnessed effectively. However, we have identified significant gaps in Defence's current communication and decision-making processes as they relate to suicide. This is discussed in Chapter 11, Governance and accountability in Defence.
310. Ensuring that the branch is able to influence change both laterally and via key decision-making forums will require consistent communication, clear articulation of risk, and escalation of emerging issues to ensure that suicide prevention remains a focus for Defence leaders.

311. A further mechanism for achieving enterprise-wide commitment will be via the joint Mental Health and Wellbeing Strategy across Defence and the Department of Veterans' Affairs (the Joint Strategy) (referred in section 15.2.2).²⁷⁴
312. We also support the establishment of the suicide expert panel as a way of ensuring that the branch has access to expert information and advice.²⁷⁵ We believe that access to such expertise will also likely increase the branch's relevance and influence.
313. This goes to the evidence we heard from Major General Jeffery John Sengelman DSC AM CSC (Retd). Major General Sengelman described the challenges he faced as a Special Forces commanding officer when he needed expertise on how to care for his unit's health and wellbeing, particularly in the context of suicide prevention, but didn't know where to turn.²⁷⁶
314. Brigadier Langford also said:
- I have a suicidologist resident in the strategic advisory group and my workforce psychologist. Now, I'm not suggesting that that is complete and so there is some work there to understand what more needs to be held within the strategic advisory group from a branch perspective.²⁷⁷
315. We would strongly encourage Defence to consider further expanding collaborations with and recruitment of experts in suicide, suicide prevention and health and wellbeing, as a crucial means of building and maintaining contemporary perspectives on suicide and suicidality.
316. This should include maintaining an awareness of the achievements of comparable military initiatives overseas. One such initiative that could be explored is the 'primary prevention workforce' model, which has been established by the US Department of Defense.
317. The research that informed the establishment of the primary prevention workforce found that that many of the preventative measures undertaken by commanders or leaders within the US military were too individualistic instead of addressing the broader organisational, social and collective norms.²⁷⁸ It further identified that prevention activities required a full-time professional workforce that was suitably qualified and credentialled to initiate and develop preventative programs.²⁷⁹
318. We think such a model would be worth exploring to see if there are any lessons to be learnt that could benefit the operating model of the Mental Health and Wellbeing Branch.

Annexure 15.1 Mental health and wellbeing programs and initiatives

The following table summarises enterprise-wide mental health and wellbeing programs and initiatives that Defence has in place to support ADF members and their families. Some of these programs are also available to Defence Australian Public Service employees.

The table is not intended to be an exhaustive list of mental health programs and initiatives that we were told about as part of our inquiry. Some of the information reflected below is at a point in time. The information is largely reproduced from responses to Notices to Give information to this inquiry.

We note that the single services have developed and deliver a range of programs and initiatives to support their members in the unique tasks associated with their specific service. These are largely not included in the below summary, which focuses on enterprise-wide initiatives.

The Mental Health Screening Continuum is discussed in section 15.5.3 of this chapter, so it is not discussed here. Initiatives provided through Defence Member Family Support are discussed in Chapter 27, Importance of families.

Table A1 Summary of mental health programs and initiatives

Name	Purpose
Suicide Prevention Program (SPP)	<p>In place in Defence since 2002, the purpose of the SPP ‘is to contribute to a reduction in suicidal behaviours and deaths by suicide in the Defence population, and to promote prevention and early intervention as pathways to positive mental health and wellbeing’.²⁸⁰</p> <p>According to Defence, in doing so, the SPP has seven key objectives:</p> <ul style="list-style-type: none"> • provide a whole-of-community approach to suicide prevention which is evidence based and outcomes focused • provide a safe environment for those at risk of suicide • reduce stigma and barriers to mental health care • build the capacity and capability of the mental health workforce to support individuals at risk of suicide • establish suicide prevention activities and services that are of high quality, accessible, appropriate and responsive to those who need them (person-centric) • enhance understanding of known risk factors and protective factors for suicide and self-harm linked with SPA (Suicide Prevention Australia) objective of a robust ‘knowledge to practice to knowledge’ system • increase the trust of the Defence and civilian community in Defence ability to address ADF death by suicide and suicidal behaviours).²⁸¹ <p>The activities of the SPP can be grouped into the following key action areas:</p> <ul style="list-style-type: none"> • suicide prevention awareness raising and skills training • clinical services, including risk assessment and safety planning and treatment • surveillance, including suicide and self-harm monitoring and reporting.²⁸² <p>We discuss the SPP in detail in section 17.2.</p>
Navy Wellbeing Program ²⁸³	<p>Navy initiated this project in 2021 to provide a ‘one-stop shop’ for the delivery of coordinated wellbeing information of a non-clinical nature. Its remit expanded to include wellbeing areas impacting all Navy people, including the use of Welfare Board and management of (non-clinical) Military Employment Classification. The project delivers a platform where wellbeing services are co-located for easy access.</p> <p>All members of the ADF have access to the Virtual Portal component of the Program, available on the internet and intranet.</p> <p>Defence told us that in 2024, the Program will transfer to Defence People Group where it will take an enterprise-wide approach.</p>

Name	Purpose
NewAccess Workplace Program ²⁸⁴	<p>NewAccess is an early intervention coaching program to support individuals with low levels of anxiety and depression. It is available to APS employees and ADF personnel on a confidential basis. No third-party referral is required to access the Program.</p> <p>The program is delivered by Beyond Blue using low-intensity cognitive behaviour therapy across six sessions. The program can be delivered through telehealth and uses psychometric tools such as the Anxiety and Depression Checklist (K10), developed in line with best practice to provide and evaluate treatment.</p> <p>Defence signed a memorandum of understanding with Comcare in 2020 to access the service. NewAccess is considered an alternative service to complement the Defence Employee Assistance Program.</p>
Reset ²⁸⁵	<p>Developed in partnership with Phoenix Australia, Reset is ‘an evidence-informed mental health prevention program’. It targets personnel experiencing mild to moderate distress subsequent to experiencing stressful events in the course of military duty.</p> <p>The Program utilises a coach-based, skills training, self-management approach. It aims to prevent progression from emerging mental health symptoms to diagnosable conditions to mitigate the associated costs to health and future capability.</p> <p>Outcomes for Reset include:</p> <ul style="list-style-type: none"> • protection and promotion of mental health and resilience of personnel • improvement in understanding and ability to detect and challenge thought patterns and emotional reactions • the building of healthy social connections • improvement in ability to respond adaptively • knowing when, where and how to seek future help <p>This training course is offered on demand to all ADF personnel, or upon request from Command. The course is delivered face to face.</p>
HeadStrength app ²⁸⁶	<p>Developed following the 2016 Senate Inquiry into the Mental Health of ADF members and veterans, the HeadStrength app provides a mechanism for users to anonymously self-check and instantly link to a range of tools and resources relevant and specific to their current level of wellbeing. The app uses evidence-based screens such as the Kessler Psychological Distress Scale 10 (K10) and the Alcohol Use Disorders Identification Test (AUDIT), which are also part of the Defence Mental Health Screening Continuum.</p> <p>Scoping activities for the development of the app began in 2017. Defence provided data on usage from 2021. The use of the app is entirely anonymous and it is available for download via ForceNet for both Android and Apple devices.</p>
On Target Harm Minimisation Program (OTHMP) ²⁸⁷	<p>The OTHMP has been in place since 2018. It builds on the former Outpatient Alcohol Treatment Program (OATP). This 4-day, tri-service group program aims to educate members who are drinking alcohol at risky levels.</p> <p>The Program is available to personnel whose alcohol or other drug use, including pharmaceutical misuse, is starting to cause problems at work, in their relationships, with their health and with the law. The training is provided in person. A self, command or medical referral is required. The Program is delivered somewhere in Australia every 4 weeks except during December and January.</p>

Name	Purpose
Mandatory Annual Awareness Training – Alcohol Tobacco and other Drug (AToD) Training	<p>This training is mandated by the Chief of the Defence Force for all members to complete annually. The mandatory brief provides members with information regarding the impact of substance use on health and includes:</p> <ul style="list-style-type: none"> • understanding the Prohibited Substance Testing Program • drugs and their effects • supplements • mental health and AToD resources <p>The training is delivered to ADF and APS personnel with unit commanders responsible for ensuring compliance.</p>
BattleSMART ²⁸⁸	<p>The BattleSMART (Self-Management and Resilience Training) was developed in 2009 by the then Directorate of Mental Health. It is a modularised educational program operating across Defence that teaches resilience training at key career points during a member's service. The program is underpinned by cognitive behaviour therapy principles.</p> <p>Defence told us that the program 'promotes both individual and collective optimal performance through the enhancement of individual coping'.</p> <p>BattleSMART's purpose is to:</p> <ul style="list-style-type: none"> • build individual/team resilience • teach a range of core coping strategies that will assist in most circumstances • prepare personnel for specific environments (training or deployment) • attain individual/collective optimal performance • provide standardised evidence-based training across the ADF. <p>BattleSMART is mandatory for all <i>ab initio</i> trainees and delivered in person. The Program is also mandatory as part of pre-deployment processes. Keep Your Mates Safe, which uses BattleSMART principles, is permanently available upon request by Command.</p>

Name	Purpose
Keep Your Mates Safe – Peer Support Program (KYMS-PS) ²⁸⁹	<p>KYMS-PS training course is made up of five modules and was implemented around 2010 in response to government direction to ‘implement a buddy system for mental health identification’ for all ADF members.</p> <p>The Peer Support Program is delivered across the single service’s training continuum and replaces a number of ad hoc mental health courses. The full training course is made up five modules:</p> <ul style="list-style-type: none"> • KYMS-Mental Health Awareness • KYMS-BattleSMART • KYMS-Low Risk Drinking Strategies • KYMS-Suicide Prevention Training • KYMS-Mental Health First Aid. <p><u>KYMS-Mental Health Awareness²⁹⁰</u></p> <p>This module was developed in 2012 and is designed to enable participants to:</p> <ul style="list-style-type: none"> • demonstrate an understanding of what being a peer in the ADF means in terms of the responsibilities in supporting others (noting that they do not replace health services) • understand the mental health continuum • recognise the signs of mental distress both in themselves and others • identify the impact of good or poor mental health on individuals, families and others. <p>Training is provided in person and is offered on demand. Navy and Air Force have stated that the course is mandatory for members in leadership courses and in <i>ab initio</i> environments.</p> <p><u>KYMS-BattleSMART²⁹¹</u></p> <p>This module aims to enable team and individual resilience, including functioning under stress. The module uses principles from cognitive behaviour therapy and is based on the BattleSMART program.</p> <p>The course is available on demand and delivered in person. Air Force has mandated the course at specific intervals across a member’s service.</p> <p><u>KYMS-Low Risk Drinking Strategies²⁹²</u></p> <p>This module aims to provide members with information on safer drinking strategies to keep themselves and others safe when drinking. It is informed by the Australian Guidelines to Reduce Health Risks from Alcohol.</p> <p>The course is available on demand and delivered in person. Navy and Air Force have stated the course is mandatory for members in leadership courses and at other intervals across a career.</p> <p><u>KYMS-Mental Health First Aid²⁹³</u></p> <p>This module was developed in 2012 and teaches mental health first aid skills and when to use them. It aims to teach participants to:</p> <ul style="list-style-type: none"> • recognise signs and symptoms of poor mental health • respond to mental health crises • understand how to engage with and support people requiring help • know where and how to get professional assistance. <p>The training is provided in person and is offered on demand to all personnel or upon request from Command. Navy and Air Force have stated the course is mandatory for members in leadership courses.</p>

Name	Purpose
Defence Wellbeing Portal ²⁹⁴	<p>The Portal is intended to improve accessibility of information on mental health issues, services and support. It is accessible on the internet and provides a single point of access to links to resources within Defence as well as reputable external organisations.</p> <p>The Portal was created in response to the 2011 ADF Mental Health and Wellbeing Strategy. It was originally released on the Defence Restricted Network but is now publicly available.</p>
Defence Mental Health Toolkit ²⁹⁵	<p>This is an information resource available on the Defence intranet that provides basic mental health knowledge to all Defence employees. According to Defence, the toolkit provides foundational knowledge on a range of topics, including:</p> <ul style="list-style-type: none"> • the impact of mental health in the workplace • common myths about mental health • a general overview of anxiety and depression • guidance on having mental health-related conversations • staying well. <p>The toolkit was developed by the Black Dog Institute for Defence.</p>
Leaders Toolkit for Optimising Mental Health and Wellbeing during Challenging Times – presentation ²⁹⁶	<p>This resource was created during the COVID-19 pandemic as a comprehensive resource for leaders at all levels to support the mental health and wellbeing of their teams.</p> <p>The Toolkit provides advice and trusted sources on five topics:</p> <ul style="list-style-type: none"> • leadership practice (supporting leadership practices related to team wellbeing) • talking about mental health (starting and managing mental health discussion with teams) • monitoring team wellbeing • supporting safety (including resources about self-harm, family and domestic violence and suicide prevention) • self-care (activities to help build individual and team resilience). <p>The Toolkit is available via the Defence intranet.</p>

Name	Purpose
Workplace Mental Health Essentials Training ²⁹⁷	<p>Workplace Mental Health Essentials Training aims to provide staff with baseline mental health literacy. There are four offerings provided under the Mental Health Essential banner.</p> <p><u>Workplace Mental Health Essentials for People Leaders – initial course</u> (introduced 2018)</p> <p>This training aims to provide participants with the knowledge and practical skills to deal with typical work-related mental health scenarios that can arise including identifying early warning signs and making appropriate referrals or arrangements. It also aims to provide strategies for creating the right environment and supporting the development of positive mental health in the workplace.</p> <p><u>Workplace Mental Health Essentials for Employees – initial course</u> (introduced 2022)</p> <p>This training is designed for employees who do not have leadership responsibility. It aims to develop essential knowledge and skills for supporting and addressing mental health in the workplace, including identifying early signs that someone may be struggling and knowing when and where to refer someone to additional support and resources.</p> <p>Both of these courses have an accompanying ‘Refresher’ course that is available.</p> <p>The training is delivered across Australia to both APS employees and ADF personnel. Individuals can register to participate on scheduled dates which are centrally funded. Teams are able to organise delivery of the course on a ‘user pays’ basis.</p>
Employee Assistance Program ²⁹⁸	<p>The Defence Employee Assistance Program (EAP) is a free, confidential and professional counselling service. It provides counselling for both work-related and personal issues. Defence told us it was available to APS employees and certain ADF personnel and their immediate families.</p> <p>Four sessions are available every 12 months and are intended in part to allow for clients to resolve work and personal issues before and if they impact work performance and general wellbeing.</p> <p>A number of offerings are available to eligible clients, including specialist helplines (for example, for family and domestic violence), programs for targeted services (such as family matters) and rapid response (for example, immediate support following a traumatic workplace event). The current EAP provider has been in place since 2017.</p>

Endnotes

- 1 Exhibit 87-01.018, Hearing Block 12, Defence Corporate Plan 2023–2027, DEF.1288.0001.0001.
- 2 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10262 [11–39]; Transcript, Angus Campbell, Hearing Block 5, 23 June 2022, p 35-3360 [26–41]; Transcript, Simon Stuart, Hearing Block 12, 22 March 2024, p 98-9947 [28–42]; Transcript, Robert Chipman, Hearing Block 12, p 91-9103 [20–38]; Transcript, Mark Hammond, Hearing Block 12, 14 March 2024, pp 92-9192 [15]–9193 [6].
- 3 National Suicide Prevention Adviser, *Compassion first: Designing our national approach from the lived experience of suicidal behaviour*, Interim Advice, August 2020, p 6 (Exhibit 47-04.009, Hearing Block 6, EXP.0006.0018.0227).
- 4 T Varker and others, *ADF members and ex-members suicide literature review: An update*, commissioned by the Royal Commission into Defence and Veteran Suicide, October 2023, p 98 (Exhibit L-01.026, DVS.2222.0001.0531).
- 5 H Kelsall and others, *Mental Health and Wellbeing Transition Study: Physical Health Status Report*, Transition and Wellbeing Research Programme, Department of Defence and Department of Veterans' Affairs, p 131 (Exhibit 20-03.044, Hearing Block 3, DEF.0001.0001.4178).
- 6 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 [Table 2, cells C27, C51].
- 7 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare, Response to Notice to Give, Attachment A, AHW.9999.0005.0001 [Table 2, cells C27, C51].
- 8 Joint Health Command, *Suicidality in the Australian Defence Force: Results from the 2010 ADF Mental Health Prevalence and Wellbeing Dataset*, May 2012, at 1598, (Exhibit BB-01.010, DEF.0001.0001.1594).
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- 11 Name withheld, Submission, ANON-Z1E7-QQAC-D, p [2].
- 12 Transcript, John Halloran, Hearing Block 7, 25 October 2022, p 52-5060 [15–22].
- 13 *Defence Regulation 2016* (Cth).
- 14 *Defence Regulation 2016* (Cth) s 49.
- 15 Exhibit 28-01.001, Statement of Susan Weston PSM, CEO, Comcare, SWE.0000.0001.0001 at 0004.
- 16 *Work Health and Safety Act 2011* (Cth) s 19.
- 17 Transcript, Susan Weston, Hearing Block 4, 11 April 2022, p 28-2552 [33–35].
- 18 Exhibit 28-01.001, Statement of Susan Weston PSM, CEO, Comcare, SWE.0000.0001.0001 at 0004.
- 19 *Work Health and Safety Act 2011* (Cth) s 12D.
- 20 *Work Health and Safety Act 2011 (application to Defence activities and Defence members) Declaration 2012* (Cth); *Work Health and Safety Act 2011* (Cth).
- 21 Exhibit 65-02.001, Hearing Block 9, Caitlin Langford, Witness Statement, DEF.9999.0075.0001 at 0010.
- 22 Exhibit 97.02.015, Hearing Block 12, ADF Health Strategy 2023, DEF.1399.0001.0029 at 0034.
- 23 Exhibit 97.02.015, Hearing Block 12, ADF Health Strategy 2023, DEF.1399.0001.0029 at 00037.
- 24 Exhibit 97.02.015, Hearing Block 12, ADF Health Strategy 2023, DEF.1399.0001.0029 at 00037.
- 25 Exhibit 97.02.017, Hearing Block 12 ADF Health Strategy Review, DEF.1399.0002.0077 at 0077-0087.
- 26 Exhibit 97.02.017, Hearing Block 12 ADF Health Strategy Review, DEF.1399.0002.0077 at 0083.
- 27 Exhibit 97.02.017, Hearing Block 12 ADF Health Strategy Review, DEF.1399.0002.0077 at 0081.
- 28 Transcript, Sonya Bennett, Hearing Block 12, 21 March 2024, p 97-9870 [6–8].
- 29 Transcript, Sonya Bennett, Hearing Block 12, 21 March 2024, p 97-9870 [24–27].

- 30 Exhibit R-01.007, Department of Defence, Defence Mental Health and Wellbeing Strategy 2018–2023, ACA.1001.0002.0403 at 0408.
- 31 Exhibit 20-03.089, Department of Veterans' Affairs, May 2020, Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020–2023, DVA.5007.0001.0011 at 0028.
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- 33 Exhibit 87-02.025, Hearing Block 12, Defence and Veteran Mental Health and Wellbeing Strategy 2024–29 (Draft Nov 2023), DEF.1311.0001.0094 at 0100.
- 34 Exhibit 87-02.025, Hearing Block 12, Defence and Veteran Mental Health and Wellbeing Strategy 2024–29 (Draft Nov 2023), DEF.1311.0001.0094 at 0100.
- 35 Exhibit CC-01.046, Commonwealth Government, Portfolio Budget Statements 2024–25 Budget Related Paper No. 1.4B (dva.gov.au), DVS.6666.0001.0989.
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- 37 Transcript, Natasha Fox, Hearing Block 12, 20 March 2024, p 96-9643 [8–13].
- 38 Productivity Commission, *A Better Way to Support Veterans*, No. 93, June 2019, vol 2, p 729 (Exhibit 01-01.011, Hearing Block 1, INQ.0000.0001.2780).
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- 40 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10337 [5–8].
- 41 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10337 [21–24].
- 42 National Mental Health Commission, Review into the Suicide and Self-Harm Prevention Services Available to Current and Former Serving ADF Members and Their Families, Final Report: Findings and Recommendations, March 2017, p 24 (Exhibit 01-01.008, Hearing Block 1, INQ.0000.0001.1488); D Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009 (Exhibit 01-01.01, Hearing Block 1, INQ.0000.0001.2000).
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- 46 Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, pp 70-6743 [39]–70-6744 [18].
- 47 Transcript, Sharon Parker, Hearing Block 10, 19 July 2023, p 70-6783 [6–22].
- 48 Name withheld, Submission, ANON-Z1E7-Q1J8-B, p [2].
- 49 MK Wilson and others, 'Understanding Fatigue in a Naval Submarine: Applying Biomathematical Models and Workload Measurement in an Intensive Longitudinal Design.' *Applied Ergonomics*, vol 94, 2021.
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- 52 Transcript, Paul Irving, Hearing Block 1, 3 December 2021, p 5-476 [10–22]; Transcript, Yvonne Sillett, Hearing Block 2, 14 February 2022, p 11-1026 [1–22]; Exhibit 73-01.028, Pathway to Change – Evolving Defence Culture 2017–22, DEF.1011.1000.2986 at 2996–2997; SK Parker and K Jorritsma, 'Good Work Design for All: Multiple Pathways to Making a Difference.' *European Journal of Work and Organizational Psychology*, vol 30, 3, 2021, p 151 (Exhibit 70-03.005, Hearing Block 10, STU.0000.0003.0148); J Drew and S Martin, 'A National Study of Police Mental Health in the USA: Stigma, Mental Health and Help-Seeking Behaviours', *Journal of Policy and Criminal Psychology*, 2020 (Exhibit 70-02.004, Hearing Block 10, EXP.0010.0001.0020); J Drew and others, *Leadership for Wellness: A Strategy for Developing Police and Public Safety Leaders*, Griffith Criminology Institute, Griffith University and Australian Institute of Police Management, White Paper, 2023 (Exhibit 70-02.006, Hearing Block 10, EXP.0010.0001.0051).
- 53 Transcript, Jacqueline Drew, Hearing Block 10, 19 July 2023, pp 70-6743 [39]–70-6744 [18].
- 54 Productivity Commission, *Mental Health*, No. 95, June 2020, vol 1, p 298 (Exhibit 64-02.012, Hearing Block 9, DEF.1152.0003.0456).

- 55 Productivity Commission, *Mental Health*, No. 95, June 2020, vol 1, p 298 (Exhibit 64-02.012, Hearing Block 9, DEF.1152.0003.0456).
- 56 Transcript, Sharon Parker, Hearing Block 10, 19 July 2023, p 70-6776 [39–40].
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16 ADF healthcare services

Summary

This chapter looks at how clinical healthcare and rehabilitation services are delivered in the Australian Defence Force (ADF) and considers whether current arrangements are meeting the needs of serving members. Accessible, quality and timely health care is critical to suicide prevention.

Based on the evidence we have heard, there are limitations in the extent to which Defence delivers timely, appropriate and effective health care, mental health care and rehabilitation services for serving members.

We also suspect that the dilution of military-specific clinical expertise and occupational understanding of ADF service is affecting the quality and appropriateness of Defence health care.

Additionally, we have identified shortfalls in continuity of care at particular points in ADF members' lives and careers, which can lead to worse healthcare outcomes. We also discuss privacy and consent, as it relates to the sharing of health information for the purpose of supporting members experiencing psychological distress and mental illness.

The Department of Defence has said that 'Defence's most important asset will always remain its people'.¹ Given the size and resourcing of the ADF and the importance it says it places on members, Defence should be a leader in the provision of health and mental health care and rehabilitation services. Based on what we have heard, we do not believe this is the case.

Due to the relatively short time available to this Royal Commission to inquire into highly complex matters, we have been unable to assess whether alternative models for delivering health care might lead to better health outcomes for members.

Due to the inadequacy of performance-monitoring and quality-improvement systems in Defence, we have also been limited in our ability to assess the quality and effectiveness of existing services.

To rectify this, we make the following recommendations and indicate areas for further work:

- Rehabilitation services must align with best practice and adopt the principle of recovering at work where it is safe to do so. Rehabilitation outcomes should also be recorded and reported publicly on a regular basis.
- Further consideration should be given to opportunities for 'unit-based' health and wellbeing support.

- The existing clinical governance framework should be strengthened to better align with the National Model Clinical Governance Framework, and systems of performance monitoring and quality improvement should be improved as a priority.
- Further clarification of privacy, information-sharing and consent policies should be refined such that unnecessary or perceived barriers do not inadvertently prevent the appropriate sharing of information for the purpose of facilitating health care and support.

16.1 Introduction

1. The Defence healthcare system is unique. It provides clinically necessary health care as well as health preparation for deployment, health support to operations, and rehabilitation services to help members return to duties or transition to civilian life. The system is also required to support commanding officers to fulfil their obligation to support the health and wellbeing of their subordinates.
2. The healthcare system is national and involves a range of partnerships and delivery arrangements using a mix of contracted, Australian Public Service (APS) and uniformed staff, as well as civilian practitioners.
3. Our terms of reference do not allow us to review the entirety of the Defence healthcare system, or to analyse the alternatives to the current system that have been proposed to us.
4. For this reason, and in line with our terms of reference, we have focused our inquiry on aspects of the Defence healthcare system that we believe are most relevant for reducing the risk of suicide and suicidality among serving members. We also acknowledge our limitations in the depth of investigation we have been able to conduct into the Defence healthcare system.
5. First, we have been limited in our ability to assess the quality and effectiveness of existing services. We attribute this to systemic issues within Defence, including a lack of system-wide performance monitoring and inadequate focus on measuring and evaluating health outcomes.
6. Second, the Defence healthcare system is unique and is not readily comparable with civilian health services. This means it is challenging to assess its performance compared to other services.
7. Notwithstanding these challenges – and in some cases, because of them – we identify areas for future work. These areas require further consideration to ensure that the defence healthcare system is structured to deliver the best outcomes for members

first and foremost, as well as increasing force capability and supporting commanding officers to discharge their responsibilities in relation to the health and wellbeing of members under their command.

16.1.1 The importance of clinical governance

8. A good system of clinical governance supports the streamlined delivery of high-quality health care and fosters collaboration among different healthcare providers, including with other acute and primary care services within a region, to deliver holistic and seamless care.
9. The unique nature of the Defence healthcare system makes good clinical governance even more important.
10. The Defence Health Manual defines clinical governance as the ‘measurement and benchmarking of clinical performance through implementation of predefined standards and established mechanisms that identify, address and continuously review problems or problematic trends that arise’.²
11. The manual stresses the importance of clinical governance in the following terms:
 - Clinical governance in the ADF ensures quality health services through executive leadership and multidisciplinary teamwork setting the agenda for and monitoring of healthcare activities.
 - It includes a program of continuous performance review supported by accurate measurement and analysis of clinical performance. Clinical and executive leaders are informed through reporting mechanisms to enable them to effectively govern and guide the performance of ADF healthcare services.³
12. In Chapter 14, Introduction to health care for members and veterans, we summarise the key components of the National Model Clinical Governance Framework developed by the Australian Commission on Safety and Quality in Health Care.⁴ These components provided a useful lens through which to consider Defence healthcare services. The issues we identified with these services are set out in this chapter.

16.2 Overview of health care in the ADF

13. The Australian Government is required by legislation to provide Australian Defence Force (ADF) members with clinically necessary medical, dental and other forms of health care that are required for them to be fit to perform their duties.⁵

16.2.1 Who is eligible for Defence health care?

14. The healthcare services an ADF member is entitled to depend on their service category (SERCAT), of which there are seven. SERCATs 6 and 7 are permanent members (6 for those doing flexible service and 7 for those in full-time service); SERCATs 2 to 5 are for reserve members; and SERCAT 1 is for Australian Public Service (APS) employees working for the ADF and who are force assigned.
15. Defence funds the clinically relevant health services required to keep SERCAT 6 and 7 members fit to perform military duties and maintain the requisite medical and physical services required under Defence policy.
16. This also extends to the provision of services required to:
 - reduce the risk of health deterioration on deployment
 - restore the health of a defence member to the level required of service (where possible)
 - provide treatment and rehabilitation for injury and health conditions.⁶
17. Reserve members (SERCATs 2 to 5) are required to maintain their physical and medical status. Defence provides the health care required for reserve members' operational preparedness, and for treatment and occupational rehabilitation of injury or illness that is a result of Defence service, until a claim determination is made by the Department of Veterans' Affairs (DVA).⁷

16.2.2 Who is responsible for what?

18. Responsibility for clinical health services is shared between:
 - Joint Health Command, which is responsible for providing health services in the garrison (on-base) environment
 - the services (Navy, Army and Air Force)
 - Joint Operation Command, which is responsible for planning, controlling and conducting operations, including coordinating health support on deployments.⁸
19. Defence members are responsible for participating in their health care. This means they are obliged to comply with the health requirements of Defence policies and disclose any health condition that creates a risk, or increases an existing risk, to their health and/or safety or that of others.⁹

20. Commanders and managers have a duty of care to the members under their command or supervision.¹⁰ As part of this duty, they are responsible for:
- ensuring members comply with directions and orders which are intended to monitor and protect the health of Defence members, and
 - conducting appropriate workplace risk assessments and taking all reasonably practicable steps for the control of likely threats to health.¹¹
21. The Commander of Joint Health Command, who usually also serves as the Surgeon General of the ADF, is responsible for the delivery of health services to enable Defence preparedness.
22. The Surgeon General of the ADF exercises technical authority over Defence health services, is the policy owner for Defence health policy and is the authoritative source of strategic health advice.¹²

Joint Health Command

23. Joint Health Command was formed in 2008 following a decision of the Chiefs of Service Committee to centralise responsibility for the delivery of health care in the garrison environment and simplify the relevant command-and-control arrangements.¹³
24. Prior to this, ADF health services were delivered to members through nine Area Health Services, six of which were under the command of the single services. The Joint Health Support Agency exercised command authority over the remaining three.¹⁴ Services were delivered by a mix of uniformed health professionals and contracted civilian professionals.¹⁵
25. Joint Health Command is also responsible for the range of policies and processes that underpin healthcare provision and includes various sub-units:
- Garrison Health is responsible for delivering garrison health services to support preparedness and operations.
 - Operational Health enables and supports the provision of integrated operational health capability now and into the future.
 - Health Business and Plans supports the alignment of the Joint Health Command's strategy, capability and resources with strategic priorities and direction.
 - Health Protection and Policy provides health surveillance, related research functions, policy and senior technical/medical advice.¹⁶
26. Joint Health Command oversees eight Joint Health Units in Australia and one at the Royal Malaysian Air Force Base, Butterworth (a permanent overseas air base for the Australian Air Force in Malaysia).

27. The eight Australian Joint Health Units are Central Australia, Central New South Wales, Northern New South Wales, North Queensland, Southern New South Wales, Southern Queensland, Victoria and Tasmania, and Western Australia. Each of these commands between three and five health centres, which may have one or more subordinate clinics at another location.
28. Joint Health Command is responsible for administering the ADF Health Services Contract.

ADF Health Services Contract

29. Since June 2012, Joint Health Command (on behalf of Defence) has contracted the provision of health services to third-party providers through the ADF Health Services Contract.¹⁷ In 2019, it was awarded to Bupa Health Services.¹⁸
30. The move to procuring garrison health clinicians was part of a larger rationalisation agenda, known in Defence as 'civilianisation'. We understand that this move was broadly intended to generate savings by converting non-combat ADF positions (such as clinicians working in the garrison environment) to contractor or APS positions.¹⁹
31. However, in April 2022, Rear Admiral Sarah Sharkey AM CSC RAN, the then Surgeon General of the ADF and Commander of Joint Health Command, gave evidence to this Royal Commission that the purpose of outsourcing ADF health care was to provide 'cost certainty' rather than cost savings.²⁰
32. While there is still a mix of ADF, APS and contracted providers, 90% to 95% of clinical health services delivered to serving ADF members in the garrison environment are procured under the ADF Health Services Contract with Bupa.²¹
33. According to Defence, as at 29 March 2022, 1,758 full-time equivalent (FTE) clinicians and administrative staff work in Joint Health Units.²² Of these, 1,152 (66%) are contracted health providers, with the remainder a combination of APS staff (320 FTE or 18%) and uniformed ADF staff (286 FTE or 16%).²³
34. To explain these numbers further, Defence advised us that uniformed clinicians have obligations that take them away from providing clinical services (such as training and exercises to maintain their deployability) and they are often found in managerial or leadership positions.²⁴

The services (Navy, Army and Air Force)

35. The services are responsible for providing operational health support via uniformed medical, nursing and allied health professionals, when members are on deployments or field exercises.²⁵
36. Each of the services has separate health agencies that are responsible for providing technical and expert advice in specific areas of military medicine. They also advise Joint Health Command on reviews into their health workforce and on any training or exercise activities likely to require significant health resources.²⁶

Joint Operations Command

37. The role of Joint Operations Command is to plan, control and conduct operations. This extends to coordinating health support on deployments (operations).
38. Joint Operations Command advises Joint Health Command, via a Health Support Order, on:

readiness requirements for deploying forces; describ[ing] and defin[ing] health effects to be delivered within the operational environment; defin[ing] the materiel and logistic health effects within the operational environment; and describ[ing] the health and governance requirements to be employed in the operational environment.²⁷
39. We note that during deployments, certain elements of the command structure for the delivery of health services remain with Joint Health Command. For example, the Surgeon General of the ADF maintains responsibility for setting the standards of health care to be delivered by the three services.²⁸

16.2.3 How are health services delivered?

40. The Defence healthcare system delivers services through a range of mechanisms. These depend on whether a member is accessing health care on base (in the garrison environment) or on deployment, and depends on the type of service being accessed. We summarise the delivery arrangements in this section.

Health care in the garrison environment

41. There are 51 garrison health centres and clinics that provide ADF members with on-base primary health care and some specialist care. According to the Defence Health Manual, these services are to 'maintain the fitness of individuals to meet preparedness requirements and to ensure wounded, ill and injured personnel receive timely, quality health care and rehabilitation'.²⁹
42. As mentioned earlier in this chapter, the vast majority of healthcare services delivered in the garrison environment are purchased from Bupa under the ADF Health Services Contract.³⁰ Garrison health services provide primary health care, with additional allied health services including physiotherapy and psychology.
43. These services include:
 - health support to operations – health preparation for deployment and post-deployment health services
 - primary health care – GPs, preventative screening, early intervention, complex case management, and health support for individual welfare boards
 - occupational health services – health screening, monitoring of occupation exposures, military employment classification reviews, aviation and underwater medicine

- occupational rehabilitation services – assessment and services to assist members returning to work, including developing rehabilitation plans, liaising with treating health professionals and supporting members transitioning from the ADF
 - dental care – general dental care, periodic dental examinations and specialist dental care for oral health conditions
 - occupational psychology – advice to command on occupational suitability of members for selection, posting and retention, and on factors related to member performance
 - in-patient care – low acuity in-patient care that is provided on base in limited garrison settings
 - pharmacy services – dispensing medications, therapeutic substances and clinically-indicated medical equipment
 - physiotherapy – triage and treatment of acute and chronic conditions, physical rehabilitation and hydrotherapy
 - pathology – screening and diagnosis services as well as specimen collection, usually on base
 - health support for specific activities – additional support for single-service activities such as training support, aerodrome emergency health support and student counselling
 - mental health and psychology services, which are discussed in more detail later in this section.³¹
44. All of the on-base medical services are available to ADF members via appointment. Acute access is available via ‘sick parade’, where members can access walk-in appointments at the beginning of each day, or the phone-based triage service (1800 IMSICK).
45. Garrison Health Support Arrangements describe the services available at each facility within the relevant Joint Health Unit.³²

Mental health clinical services

46. The clinical mental health care available to serving members includes on-base primary health care and off-base specialist and hospital care.
47. In addition to clinical mental health services, various mental health promotion and prevention programs are offered to Defence members, as well as mental health screening. These initiatives are discussed in Chapter 15, Promoting health and wellbeing among ADF members. We discuss the ADF Suicide Prevention Program separately in Chapter 17, ADF and DVA suicide prevention programs and initiatives.

48. Mental health and psychology services operate in the garrison environment from 37 clinics and health centres.³³ They provide organisational psychology services and clinical mental health services, including intake, comprehensive risk assessments, mental health treatment, and multidisciplinary case allocation and case review.
49. According to Defence, as at 29 March 2022, there were 115 FTE positions providing mental health and psychology services across garrison health services. These include uniformed staff (7%), Australian Public Service employees (23%) and contracted health providers (69%), and include psychologists, psychiatrists, mental health nurses and social workers.³⁴
50. Across the three services, different arrangements have historically existed for providing mental health and psychology support. Most notably, in 2021 Defence disbanded Army's dedicated unit providing deployable psychology capability (1 Psychology Unit). This decision was made as part of a 2023 restructure which saw the consolidation of Army's deployable health personnel into one dedicated health brigade (2 Health Brigade).³⁵
51. Defence explained this decision, saying:
- mental health care is not the exclusive domain of Army psychologists; it is a collective effort delivered by general practitioners, mental health nurses, psychiatrists, a variety of other health care providers, including psychologists in JHC [Joint Health Command], and is supported by the Chain of Command.³⁶
52. They went on to differentiate between the roles of Army Health Services and Joint Health Command (JHC):
- JHC are responsible for the provision of clinical care in the non-deployed domestic environment. They execute this service using a range of professionals in addition to psychologists, to support the delivery of mental health care, replicating those service providers available in the civilian community. Army Health Services are responsible for the conservation of Army's workforce to maintain operational capability and contribute to operational success. The focus is on the deployed environment and the health capability structure allows Army to have access to a psychology workforce that can be readily deployed.³⁷
53. At the same time as the disbanding of the 1 Psychology Unit, the psychological examiner trade (job category) was removed.³⁸ Psychological examiners had supported data management and analysis, the design and coordination of screening forms, and the development of training resources.³⁹ They also provided technical and practical support to service delivery in garrison and on operations.⁴⁰
54. Defence has confirmed that since closing the 1 Psychology Unit and removing the psychological examiner trade, psychologists and Joint Health Command have both seen an increase in workload, including an increase in the administrative burden on psychologists.⁴¹

55. We have heard personal experiences of how these changes have impacted Defence psychologists. As one wrote in a submission:

The examiners were a brilliant segment of the workforce. They provided me great assistance in my early career which expedited my understanding of the environment that I had to function within. As Other Ranks they also had well developed links to units and often had insider information that enhanced my decision making as a Psychologist. They also provided significant administrative support which now falls to the psychologist who should instead be working to the top of their skillset. They were also a ready-made 'peer support' workforce terminated at a time when the rest of the world was starting to focus on ... peer support and lived experience.⁴²

56. Another witness told us:

In my opinion [psychological examiners] played integral roles in enabling military psychologists to provide accurate and targeted support to Defence members. They eased administrative burden to ensure appropriate record keeping and allow psychologists to spend more time functioning within their trade. They are able to provide appropriate peer support and facilitate referrals for mental health support, training or advice where appropriate, in liaison with Military Psychologists. This organisational loss happened with significant hollowness in the Military Psychologist capability [which has] reduced ability to engage with the military population it supports.⁴³

57. Defence conceded certain poor outcomes that occurred following the disbanding of the 1 Psychology Unit, noting that:

It has also impacted on the feedback loop associated with psychological lessons learnt from operations and the ability to quickly utilise information obtained through Return to Australia Psychological Screening (RtAPS) to understand particular issues that may be emerging within specific operational areas or roles. This information is still obtained through operational mental health surveillance processes, however direct and immediate feedback through 1 Psychology Unit, or its replaced structure, no longer occurs⁴⁴

58. In section 16.4.1, we discuss the need for health and wellbeing support to be provided at the point of need – for example, embedded within units. We also think it would be appropriate to review current arrangements for delivering psychology support. Consideration should be given to whether the recent changes discussed in this section have delivered the intended benefits or whether there have been any unintended consequences, such as a loss of peer support and necessary feedback loops.

Health care on deployment

59. While on deployment, ADF members do not have access to the full suite of healthcare services.⁴⁵ In certain circumstances, care might be supplemented with local healthcare services.

60. When a member requires care beyond what is available on deployment, they are transported to locations where higher-quality care can be provided.⁴⁶ Captain Ian Young AM RAN, Director of Fleet Health, told us that decisions regarding medical evacuations are primarily operational in nature, and that:

[t]here may be tension with the Commander if the need to land an injured member ashore affects the mission. Ultimately, the risk to mission and personnel is managed and accepted by the Commander.⁴⁷

Off-base specialist health services

61. Specialist services are normally delivered via various off-base services when a clinical need cannot be met at the relevant facility. These services are:

- specialist medical, mental health and dental services for the treatment and management of health conditions
- allied healthcare services including dietary advice, exercise physiology, audiometry, visual assessment and optical aids, hand therapy, podiatry, occupational therapy, speech therapy, and clinical and non-clinical aids.⁴⁸

62. On-base health staff remain responsible for coordinating care, including referrals, as well as health administration and health record management across on-base and off-base health services.⁴⁹

Rehabilitation services

63. Defence differentiates between two forms of rehabilitation that it provides to injured or unwell members:

- 'Clinical' rehabilitation is provided to members who have some form of temporary impairment that limits their movement, function or ability to perform their job.⁵⁰
- 'Occupational' rehabilitation is for members with a longer-term impairment and is delivered through the ADF Rehabilitation Program. It includes both physical rehabilitation and support to return to the same or a different role or to separate from the ADF.

Clinical rehabilitation

64. Defence told us that clinical rehabilitation is generally provided by on-base physiotherapists and physical training instructors. Where available, it includes exercise therapy and exercise physiology.⁵¹
65. Members generally access clinical rehabilitation by presenting to 'sick parade' at their base's health centre or making an appointment with an on-base physiotherapist.⁵²
66. Rehabilitation programs are developed by the member's treatment team (which may include physiotherapists, physical training instructors and exercise physiologists) in consultation with the member and taking into consideration short- and longer-term rehabilitation goals, which are monitored at every appointment.⁵³

Occupational rehabilitation

67. The ADF delivers occupational rehabilitation through the Australian Defence Force Rehabilitation Program (ADFRP):

[It] is a managed process involving early intervention with appropriate, adequate, and timely services based on assessed needs and is aimed at maintaining injured or ill members in, or returning them to, suitable employment.⁵⁴
68. Defence describes the ADFRP as a 'holistic approach that considers the individual's psychological, physical, social, and vocational circumstances. It provides holistic rehabilitation by involving members, families, treating health practitioners, rehabilitation consultants and community support'.⁵⁵
69. The ADFRP is based upon principles of the biopsychosocial model for rehabilitation.⁵⁶ This model involves assessing and managing multiple factors that may act as barriers to rehabilitation. They are categorised as:
 - bio – body structures and function
 - psycho – personal and environmental factors
 - social – activity and/or participation, and environment.
70. According to the ADF, a serving member can self-refer to the ADFRP or be referred by their chain of command, a medical officer or DVA if they have an injury or illness that affects their ability to perform their duties.⁵⁷ It is mandatory for medical officers to refer members for an occupational rehabilitation assessment if their military employment classification (MEC) is downgraded to MEC 3 or MEC 4.⁵⁸ (See Chapter 5, The military employment classification system and medical separation, for further details.)
71. A member referred for occupational rehabilitation via the ADFRP undertakes a rehabilitation assessment to assess their capacity to return to a state of readiness through rehabilitative activities.⁵⁹

72. If rehabilitation is determined to be a viable option, the member follows a rehabilitation plan designed to support their return to their role or another suitable ADF role. In some instances, the process facilitates their separation from the ADF.⁶⁰
73. When a member is referred to the ADFRP, a rehabilitation case manager assigns the referral to a rehabilitation consultant which, according to Defence, is decided based on the availability of consultants linked to the member's unit and on-base and off-base rehabilitation consultants.⁶¹ Rehabilitation consultants are employed by Comcare-approved workplace rehabilitation providers.⁶² Comcare determines who is suitably qualified to provide rehabilitation. Professions include:
- registered health practitioners who are registered to practise as an occupational therapist, physiotherapist, psychologist, medical practitioner or nurse
 - rehabilitation counsellors with appropriate professional membership
 - exercise physiologists who are accredited with Exercise and Sports Science Australia
 - social workers who are full members of the Australian Association of Social Workers.⁶³
74. The rehabilitation consultant is responsible for conducting the rehabilitation assessment, deciding whether a rehabilitation program is required, and if so, formulating, implementing and case managing the member's program.⁶⁴
75. We heard that Defence has had issues filling rehabilitation consultant positions. In particular, we heard from Lieutenant Colonel Stewart Holmes-Brown, Senior Medical Officer of Townsville's Lavarack Barracks, that:

The ADFRP workforce is considered the major area for improvement. Since the implementation of the ADF Health Services Contract (ADFHSC) with Bupa (and the Rehabilitation subcontractor Acumen), [Joint Health Unit – North Queensland] has experienced significant workforce turnover and long-term Rehabilitation Consultant vacancies. This has resulted in one unit on Lavarack Barracks having six different RCs [rehabilitation consultants] in the past 36 months, with four of these in the past 18 months. There are also significant numbers of cases yet to be allocated to an RC, currently ... approximately 80 cases. Efforts have been made to improve this, with an additional three RC positions added in 2021; however, these have remained unfilled for the majority of the time since they were created, with only short-term fill.⁶⁵

76. It does not take much to imagine that a high level of turnover of rehabilitation consultants would reduce continuity and quality of care for ill or injured members. As Lieutenant Colonel Holmes-Brown told us:

[W]hen you have churn of workforce, there's constant handover, there's ... members [constantly] needing to retell their story to a new rehabilitation consultant, there's chain of command having to establish relationships again and it just creates difficulties that can impact someone's rehabilitation.⁶⁶

Rehabilitation units and 'platoons'

77. Part of the suite of rehabilitation services provided by Defence is a number of units that, according to Defence, provide additional support to members undertaking a rehabilitation program.
78. These units include personnel support units (PSUs), the Trainee Rehabilitation Wing (for injured trainees), soldier recovery centres and 'platoons'. Platoons are the name given to units that support injured or ill cadets (including Sir Neville Howse VC Platoon and the Roden Cutler VC Platoon) and recruits (including the Digger James Platoon and the Weary Dunlop Platoon).⁶⁷
79. According to Defence, PSUs, while not specifically 'rehabilitation units', provide members posted there with unconditional support to ensure they can fully participate in the ADFRP.⁶⁸ There are eight PSUs that provide additional support for members with 'multifaceted personal issues' (namely administrative, disciplinary and/or medical issues).⁶⁹ Each PSU is managed by an officer in charge, who is supported by divisional officers.⁷⁰
80. The Trainee Rehabilitation Wing is for trainees who are injured during their period of initial training at a training establishment. It aims to facilitate a focused recovery program and is located in Sydney.
81. Soldier recovery centres were established in 2011 to assist in the overall recovery of injured or ill soldiers. They provide structured and holistic support across four 'pillars':
 - Body (physical) – individual and group physical training activities, nutrition and reconditioning to develop lifelong healthy habits.
 - Mind (intellectual) – active engagement in intellectually engaging and challenging training and education opportunities.
 - Social (community) – to provide a sense of belonging to community and promote engagement with local people and wider Australian society.
 - Spirit (character) – sense of purpose, self-worth, and esprit de corps.⁷¹
82. Soldier recovery centres were originally set up to assist members returning from overseas deployments; however, these centres are now seeing an increasing number of referrals for injuries that have occurred domestically. Referrals from overseas deployments have decreased.
83. The decision to send a member to a soldier recovery centre is usually made at a 'welfare board', where the member, their chain of command, rehabilitation consultant and medical professionals decide whether this is the best place for the member to recover.⁷²
84. Attendance at a soldier recovery centre requires a member to be away from their unit for up to eight weeks.⁷³ Similarly, attendance at the Trainee Rehabilitation Wing will require a geographical move for most participants.

85. Sir Neville Howse VC Platoon provides individually tailored medical and vocational rehabilitation to injured or ill staff cadets, enabling them to return to training.⁷⁴ The Roden Cutler VC Platoon is responsible for managing staff cadets who are separating from the Army for administrative or medical reasons.⁷⁵
86. The Digger James Platoon manages recruits undergoing rehabilitation for injury or illness. The Weary Dunlop Platoon is for managing recruits separating from the Army for administrative or medical reasons.⁷⁶
87. In section 16.3.4, we identify issues related to rehabilitation. We are concerned that individuals feel a sense of isolation when posted to these rehabilitation units and ‘ platoons’, which is not conducive to good health outcomes. We are also concerned that such units may not be positive environments that genuinely support rehabilitation.

Health care through civilian service providers

88. We heard evidence of ADF members seeking health care from the civilian system for various reasons, including because specialist care organised within the Defence system was unavailable or involved too long a wait. Sometimes they said it was to protect themselves from repercussions within Defence for seeking treatment.
89. Members seeking treatment in the civilian sector are potentially eligible for reimbursement of their costs. Defence told us that between 2017–18 and 2022–23 an average of 1,926 members received reimbursement for external health care each year, mostly for GP and pharmacy services.⁷⁷
90. Defence told us that they understand that ‘members may seek external care for several reasons, including fear of impact of a health condition on employability and deployability, convenience or choice’.⁷⁸ We note that the number of members receiving reimbursement for external care is likely to exclude those members seeking it to avoid repercussions of various kinds.

16.3 The link between health care and suicide prevention

91. As we discuss in detail in Chapter 1, Understanding suicide, there is a range of risk and protective factors for suicide and suicidality. Featuring among these are risk and protective factors associated with health care.
92. For instance, the development of certain physical and mental health conditions (which are set out in more detail in Chapter 14, Introduction to health care for members and veterans) can increase the risk of suicide and suicidality. Timely access to medical care and mental health services, and effective treatment or symptom management can be protective.

93. We also know involuntary medical discharge is a risk factor for suicide, as we discuss in Chapter 5. This highlights the importance of effective rehabilitation programs to increase opportunities for injured and ill members to recover and remain within the ADF.
94. Unfortunately, our inquiry has highlighted several issues that we contend negatively impact the health and wellbeing of serving members. They are not peripheral issues but rather lie at the heart of suicide prevention because they negatively impact the effectiveness, timeliness, accessibility and quality of the health care and rehabilitation services provided to members. They are described in the following sections.

16.3.1 Do civilian clinicians have the specialist capabilities required?

95. ADF healthcare workers are generally not recruited with specialist capabilities to manage the main kinds of injuries and illnesses experienced by serving members, namely musculoskeletal injuries and conditions associated with mental ill health and psychological injury.⁷⁹ In addition, we have seen no evidence that their employment conditions in any way incentivise the development of military-specific clinical capabilities.
96. We are also concerned that civilian clinicians have a limited occupational understanding of ADF service. This has the potential to impact the quality and safety of health care in the absence of appropriate support and training.

Lack of specialisation in conditions prevalent among Defence members

97. Healthcare workers recruited under the ADF Health Services Contract are not required to have a specialisation in the conditions prevalent among members (which we describe in Chapter 14), or any pre-existing knowledge of the Defence environment.⁸⁰
98. Contracted medical officers are only required to satisfy the following general criteria:
- Current unconditional and unrestricted registration as a Medical Practitioner, General in Australia with the Australian Health Practitioners Regulation Agency (AHPRA);
 - A Fellowship of the Royal Australian College of General Practitioners (FRACGP), Fellowship of the Australian College of Rural and Remote Medicine (FACRRM), Vocational Registration or equivalent suitable experience and training as assessed by the Commonwealth;
 - A minimum of 2 years full-time experience in general practice setting within the last 5 years (or part-time equivalent); and
 - Current Cardiopulmonary Resuscitation (HLTAID009) certification.⁸¹

99. Knowledge and/or experience of military service and its health effects on members is not even listed as a 'desirable criteria',⁸² nor is any special expertise or knowledge of conditions prevalent in serving and ex-serving members required.
100. This is also true of other healthcare roles, with the exception of psychiatrists, for whom it is desirable to '[have] knowledge of psychological and mental health impact of working in the military environment and its effects on the functioning of members and their families'.⁸³
101. We heard evidence that, because they are recruited as generalists, contracted healthcare providers may not have sufficient or appropriate capabilities for clinical diagnosis and care of musculoskeletal conditions or the management of specific occupational risks associated with ADF service.
102. For example, Dr Stephan Rudzki, a former uniformed medical officer, gave evidence that contracted medical officers often lack expertise in the diagnosis and treatment of musculoskeletal conditions:

[W]hen we look at how Defence is delivering its health services at the moment, it has a committed and dedicated workforce but none of them have any expertise in the diagnosis and management of musculoskeletal injury. They are general practitioners, by and large ... and if one looks at the general practice college syllabus ... frankly, I don't believe they have the requisite knowledge, skills and expertise to correctly manage these injuries.⁸⁴

We have general practitioners contracted to serve and provide care in our facilities. They, to my knowledge, don't get any specialist musculoskeletal training. There is very little musculoskeletal training in the general practice syllabus, and it's a mile wide and an inch thick. If you don't know what you are doing, you can't really do a very good job.⁸⁵

103. However, Defence disputes this assertion saying that '[musculoskeletal] medicine is part of the General Practice curriculum' and '[musculoskeletal] presentations commonly occur in General Practice and GPs are qualified to determine whether referral to a physiotherapist, sports physician or orthopaedic surgeon is most appropriate'.⁸⁶
104. While we note Defence's response, we do think there is an opportunity to support ADF healthcare workers to further develop their knowledge and expertise in diagnosing, treating and managing the most prevalent conditions within ADF members.

Occupational understanding of ADF service is crucial

105. Upon engagement, contracted clinicians are not required to have any occupational understanding of the Defence environment, including the risks associated with ADF service. However, new healthcare workers are provided with basic training in relation to the Defence environment and occupational activities prior to their commencement.⁸⁷ Additional training is also provided throughout their tenure.⁸⁸

106. We think it is crucial that the contracted workforce has a thorough and practical understanding of ADF service.
107. Without this, clinicians who are responsible for clearing ADF members to return to duty may have a poor understanding of what that duty entails, leading to members being cleared for duty too early. Professor Rob Orr, a physiotherapist with uniformed ADF experience, described clinical risks associated with the lack of specific occupational knowledge on the part of contracted clinicians. Recounting his experiences when he was a uniformed physiotherapist, he told us:

I actually took our physiotherapists out, our civilian contractors, and showed them an Army PT [physical training] session ... I then took them out to the range and got them to do a rifle shoot.

Many of them were shocked when they first saw the PT session, at how physically demanding it was, what it looked like, because they had no contextual knowledge of it ... When we said, 'When you clear them for duty, when you clear them to go back to training, you are happy for them to turn up tomorrow and do this level of training?' They went, 'Hell no.' ... So that contextual knowledge, I think, is often lacking ... The context and the ability to understand what the military requirements are, and what they look like in the real world, creates a knowledge gap.⁸⁹

108. In June 2024, Defence told us that Joint Health Command is enhancing its existing orientation and induction program to better support cultural competency and understanding of the Defence health system amongst all new starters.⁹⁰
109. We welcome this development. We heard evidence that uniformed clinicians in the ADF who have a stronger understanding of the occupational dimension of ADF service and its intersection with health care are better able to support members.
110. Ms Pennie Looker, a former serving member and former psychological examiner with the Army, gave evidence saying her role as a psychological examiner was 'vast', from delivering psychoeducation briefs to working with psychologists and implementing screening tools.⁹¹ She spoke of the benefits of having military knowledge and a Defence background when undertaking that role in uniform:

[W]e've been through the same as everyone else. We've done the same training, we go on deployments, we go out [into the] field the same ... So there is a camaraderie and rapport that is built up there ... On deployments particularly, we're sitting amongst the [other ranks], we're sitting there chatting, even in the messes back home. We are associating with them, socialising with everyone, just like they do. So there's that ability to build rapport before they even walk through the door for a screen or testing or anything else. So there is a level of trust, a level of camaraderie that we're able to build.⁹²

111. Prior to the establishment of Joint Health Command in 2008, and the subsequent contracting out of most health services in 2012, uniformed clinicians were attached to units.⁹³ From what we have heard, under this arrangement clinicians had greater access to commanding officers and potentially a greater ability to identify issues in members earlier and facilitate support and treatment.⁹⁴

112. Dr Phil Parker, a former uniformed medical officer, also gave evidence about the benefits of uniformed clinicians maintaining a connection with their unit:

There was a time when I did work at one of the infantry battalions at Enoggera, before ... all the health support came in, and a young soldier came to me, and it was clear to me that he was struggling significantly. I could have put in restrictions and all sorts of business and sent him off to the psychologist. But what I did, I knew his platoon sergeant and I said to that platoon sergeant, 'You need to ease off this guy. He is struggling at home, he's got issues happening.' As soon as that happened, things changed. That's what happens, that's that familiarity, that's the benefit of it, when you know people and you understand the environment and you understand how things work, you can actually manage things quite easily without ascending to higher level expensive specialist care.⁹⁵

113. Dr Parker also told the Royal Commission that the centralisation of a uniformed medical workforce made him feel like 'a commodity'. He told us that 'as soon as that happened, [he] felt less motivated to continue in that role ... [he] felt devalued'.⁹⁶

114. Dr Stephan Rudzki AM, a former uniformed medical officer now practising privately as a sports and exercise physician, told us he is 'not convinced that the current system [of centralised health services] delivers the promised outcomes or is as effective as its proponents advocate'.⁹⁷ With no small amount of insight, he said that 'by separating the nexus between garrison and operation, you lose the military context'.⁹⁸

115. To address these issues, in section 16.4 we discuss opportunities for providing greater health and wellbeing support at the 'point of need', that is, within units. This wouldn't necessarily require additional uniformed clinicians, though there may be many benefits in increasing their number. We remain open to the idea that greater linkages could be facilitated between garrison health clinicians, whether contracted or not, and commanding officers.

16.3.2 Health services are not always accessible, available and timely

116. Defence has told us that ADF members have access to health care at a comparable level to the broader population, if not better.⁹⁹ However, we are aware of a number of circumstances that undermine members' ability to access health care.

Issues with wait times

117. During our inquiry, many serving and ex-serving members told us about the long delays they experienced in accessing appropriate treatment for physical and mental health conditions. Many said they waited months for appointments.¹⁰⁰

118. As one member told us:

My injury was primarily exacerbated by the objectively abysmal health care I received from the [redacted]. The earliest I could book a doctor's appointment was in two months, and this extremely long wait time for appointments continued throughout my time at [redacted]. Even when I went to sick parade multiple times a week, every week, I was just brushed off by the nurses and/or doctors who saw me. They would dismiss me as having some sort of mild strain or muscle soreness. The only actions they took were to prescribe me with a weak painkiller or anti-inflammatory, even when I would tell them the previous doctor/nurse had done that and it made no difference.¹⁰¹

119. Similarly, Brigadier Kahlil Fegan DSC, former Commander of the 3rd Combat Brigade, told us that he knew there could be significant delays in accessing non-urgent health care:

There are challenges. I think, from my perspective as a combat brigade commander, one of the frustrations is how long it takes to get an appointment if it is not a priority issue. So, a niggling injury, be it physical or mental, in the early stages where you are starting to realise that there is a problem and you put your hand up, prior to getting assistance there may be a wait time of anywhere between four to eight weeks. I think that in many ways disincentivises people from putting their hand up because they know they are not going to be able to necessarily get the assistance unless they are prioritised, in the case of an emergency, early.¹⁰²

120. The lack of timeliness in the delivery of care can act as a barrier to access. One member spoke about their time in ADF leadership:

Defence provides a false sense of [members'] ability to access timely physical and mental health resources and services. Having been in positions of command, I would encourage and expect my soldiers to seek out these resources to ensure they maintained fitness for service, yet my experience has highlighted that these services are not timely and as a result, place increased pressure on individuals. I believe that **the lack of timely access to support services is a policy failure that is resulting in people exiting Defence under precarious circumstances** ... Timeliness is a barrier to entry for the effective support that physically and mentally wounded Defence personnel require to continue serving their communities.¹⁰³

121. Another member spoke about waiting times:

How this typically looks is that when a service member wishes to visit a GP within the defence medical system there are waiting time that will range from 2 weeks to 8 weeks even up to 10 weeks in some cases. This is a very common occurrence within all defence bases. This is not even just for a particular doctor but to see any medical staff.¹⁰⁴

122. Given the concerns we heard regarding the timeliness of care, we asked Defence to provide us with average and median wait times from 2019–20 to 2022–23 for all health centres and clinics.¹⁰⁵ We did not find major differences in the wait times across these time periods, so will focus on the most recent data for 2022–23.

123. In relation to wait times (that is, the time between when a member books an appointment and attends that appointment) for accessing medical services, almost 95% of health facilities had an average wait time of at least a week (68% had a median wait time of at least a week).¹⁰⁶ For mental health services, over 80% of facilities had an average wait time of at least a week (58% had a median wait time of at least a week).¹⁰⁷

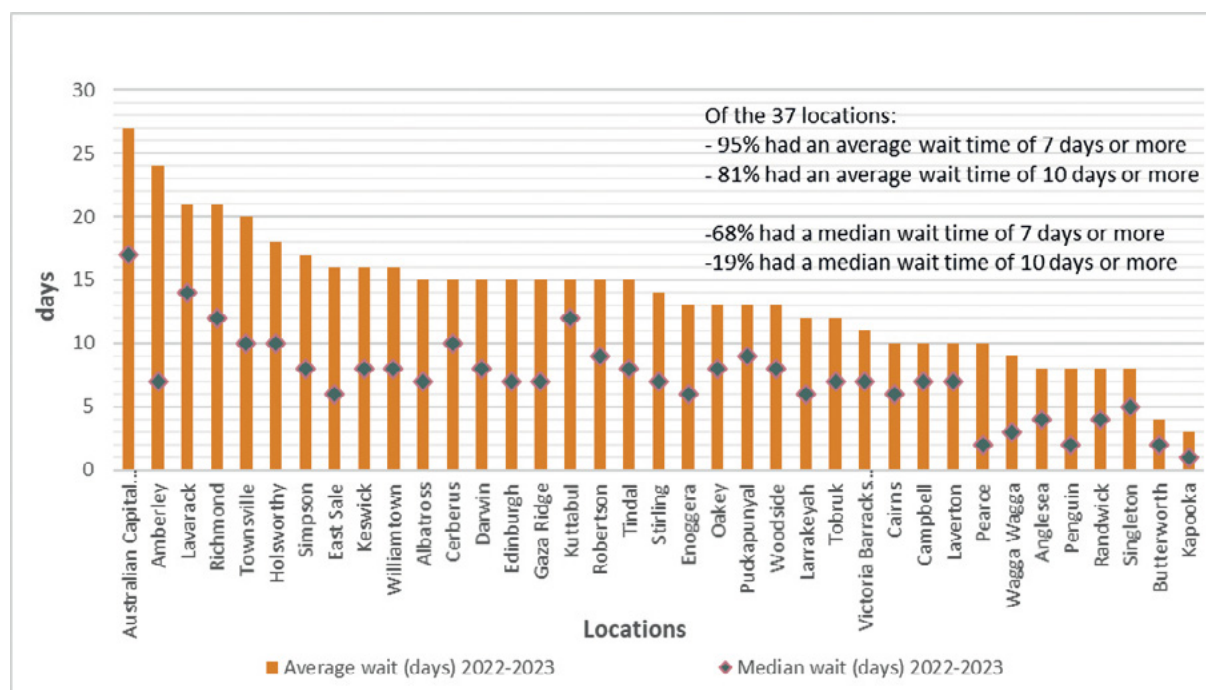
124. We found that there is significant variability in wait times across health facilities, meaning some members are waiting a very long time.

125. For example, in 2022–23, the average (mean) wait time in days for accessing medical services in the Australian Capital Territory was 27 days and the median wait time was 17 days. When the mean is much higher than the median, the data is said to be ‘positively skewed’, which means some members waited *a lot* longer than 27 days to access medical services.

126. For accessing mental health services, in 2022–23 the longest wait time in days was reported in Darwin, which took on average 19 days (with a median of 18 days). Given what we know about the circumstances under which members may decide to seek help for mental health issues – that is, we know there is a general reluctance to seek help and members may not do so until their symptoms are reasonably intense – a wait of almost 3 weeks to see a mental health clinician is a long time.

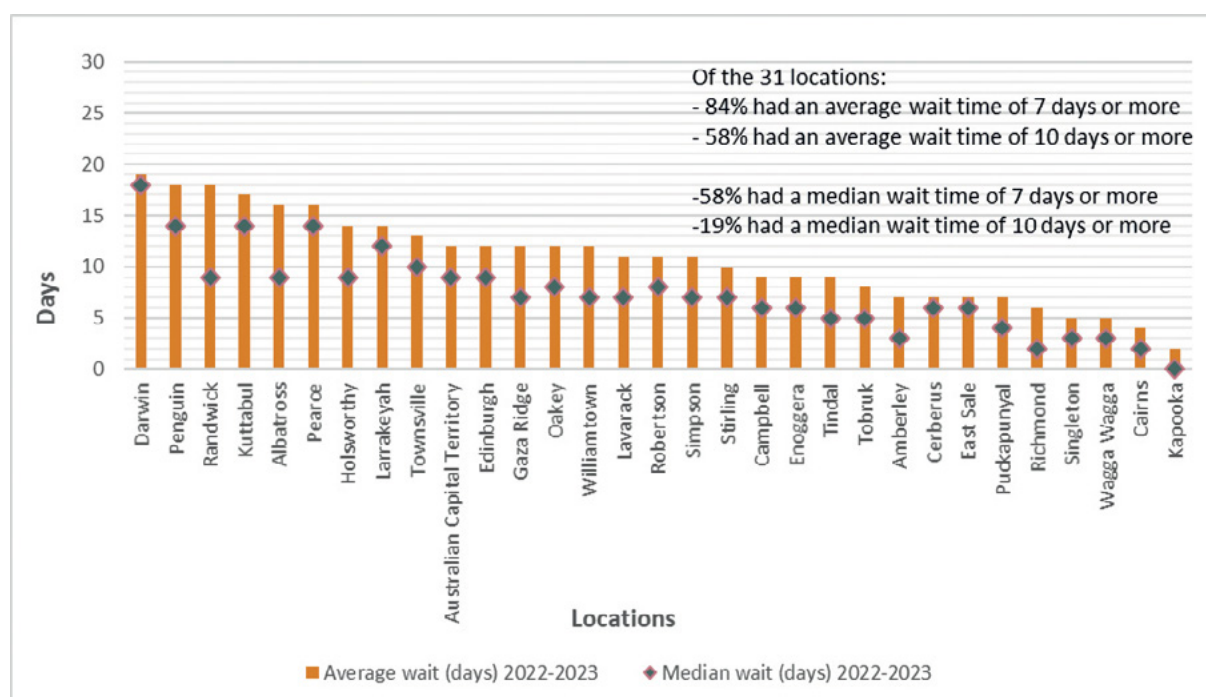
127. This data is presented in Figures 16.1 and 16.2 for all locations and for medical services and mental health services respectively.

Figure 16.1 Average and median wait times for accessing medical services 2022–2023



Source: Department of Defence, response to NTG-DEF-185, DEF.9999.0121.0001, Table 2.1.

Figure 16.2 Average and median wait times for accessing mental health services 2022–2023



Source: Department of Defence, response to NTG-DEF-185, DEF.9999.0121.0001, Table 2.3.

128. We note that the wait times presented above are for what Defence refers to as ‘non-urgent’ appointments; according to Defence, members with acute or urgent health needs will be seen the same day through ‘sick parade’.¹⁰⁸ Defence also told us that the date the member attends an appointment may not necessarily represent the first available appointment. Rather it may be the result of a member’s preference – either in terms of timing or to see a particular practitioner.¹⁰⁹
129. Defence appears to be aware that some members wait a long time for health services. The 2022 Wellness Action Through Checking Health (WATCH) project, commissioned by Defence, sought to identify early signs of mental ill health. This project found that long wait times were a major barrier to help seeking for ADF members.¹¹⁰ Health service providers identified ‘lack of time’, ‘lack of staff’ and ‘staff spread too thinly’ as the primary barriers to implementing effective strategies for early intervention.¹¹¹
130. We understand that the WATCH project assisted Defence in developing an evidence base to inform future strategies and initiatives.¹¹² However, from our inquiries, we are not aware of specific initiatives arising from the WATCH project that directly address lengthy wait times.
131. We are concerned that, while we hear a lot about stigma, a culture of self-reliance and even the threat of career repercussions as reasons why members may be reluctant to seek help for physical and mental health issues, what we have found is that long wait times are just as much of an issue. This is significant. We would argue that wait times are within Defence’s control and possibly easier (or at least quicker) to modify than an individual’s self-stigma and heightened self-reliance.

Issues with health workforce shortages

132. Defence has said openly that it is facing a health workforce shortage, which it says increases the time members have to wait for routine appointments.¹¹³ In some cases, due to supply issues, members may be required to see healthcare providers outside of their location, which entails more travel time for them.¹¹⁴
133. Dr Robert Worswick, a former Army medical officer, and then Senior Contracted Clinician with Defence, told us about understaffing in Wagga Wagga and ACT Health Centres, which led to longer wait times for follow-up appointments and decreased continuity of care.¹¹⁵ He says the root cause of this problem is:
- [an] understaffing of doctors and on-base psychologists. Defence spends [a] significant amount of money referring to off-base specialists (including civilian GPs) because the on-base clinicians are unable to meet the clinical workload; yet Defence (Joint Health Command) seems unwilling/unable to increase its contracted clinical workforce.¹¹⁶
134. Dr Worswick also highlighted the increased burden on clinicians caused by the higher demand for care.¹¹⁷ He attributes this to a range of factors, including pre-existing medical conditions of new recruits, injured trainees, and non-deployable personnel,

all of which have increased healthcare requirements.¹¹⁸ He expressed certainty that health care for members is not optimised because clinicians are overwhelmed by their clinical workload.¹¹⁹

135. A mental health nurse with recent experience working in garrison health services told us that of the three bases she worked on, all were ‘significantly understaffed and under-resourced’.¹²⁰
136. At our hearing in Darwin, Wing Commander Martin Parker told the Royal Commission he did not think that just one mental health registered nurse was sufficient for the number of members located at RAAF Base Tindal.¹²¹ Similarly, Squadron Leader Victoria Dews told the Royal Commission that there was enough demand at RAAF Base Tindal for a third full-time GP without wastage.¹²²
137. Bupa has also provided evidence of major issues with workforce supply. It is Bupa’s opinion that five supply challenges have impeded its ability to attract and retain clinicians under the ADF Health Services Contract. They are:
 - Australia-wide vacancies in healthcare positions
 - a reduced pool of available healthcare workers
 - significant choice available to healthcare workers
 - a narrow pool of available healthcare workers
 - the geographical location of Defence bases.¹²³
138. The Royal Commission acknowledges the difficulty of attracting and maintaining a health workforce. It acknowledges, too, that this situation is not unique to Defence. The National Skills Commission’s 2023 Skills Priority List notes that recruitment for the health workforce is a challenge nationwide.¹²⁴
139. Workforce supply issues, especially in relation to mental health workers, are also not new. In 2017, the National Mental Health Commission published its *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*. It recommended that Defence further enhance specialist mental health expertise within the ADF, ‘with options including a greater number of military psychiatrists, engagement of mental health nurse practitioners, and more allied health practitioners with clinical mental health expertise (e.g. clinical psychologists)’.¹²⁵
140. The National Mental Health Commission noted that the cost of these changes could be offset by reducing outsourced mental health specialist services and that mental health peer workers could complement the expanded clinical professional roles.
141. The Australian Government response to this review noted that Defence had a number of actions in place to ‘expand specialist mental health expertise within Defence Health Services supported by an expansion of the role of the ADF Centre for Mental Health’.¹²⁶

142. In 2019, Defence closed this recommendation, noting that attracting appropriate candidates for uniformed psychiatrist positions had been ‘challenging’, but that it nevertheless remained committed to recruiting uniformed psychiatrists.¹²⁷ It justified the closure of the recommendation by referencing its ‘access to over 320 psychiatrists, a large number of allied health professionals and a broad range of programs, through the ADF Health Services Contract’.¹²⁸ We think the closure of this recommendation without any clear improvement was premature.
143. Defence has since made attempts to increase the contracted mental health workforce within Joint Health Units and it has increased the number of uniformed psychiatrists. According to documents provided by Defence, between January 2022 and April 2023, the Commander of Joint Health approved 57 new contracted mental health professional positions.¹²⁹ Whether or not all of these positions have been filled is not clear to the Royal Commission.
144. We also note that Defence has introduced various innovations to meet demand, and strategies to attract staff, including targeted employment campaigns.¹³⁰
145. Rear Admiral Sharkey spoke of innovations to the Defence health service delivery model to address demand, including fly-in/fly-out opportunities and an increased use of telehealth and telepsychiatry, although she conceded more could be done.¹³¹
146. As stated earlier in this chapter and elsewhere in this report, the importance to members of timely access to safe, quality care cannot be understated. Not only is adequate health care implicitly and explicitly promised to serving members, it is doubly protective against suicide and suicidality. This means it is directly protective and may also protect against other risk factors for suicide and suicidality, such as involuntary medical discharge.
147. We therefore strongly urge Defence to consider further ways to meet demand and increase the value proposition of ADF health services to health practitioners. This ought to include further consideration of strategies to develop and support a peer workforce, as we believe the potential of peer support programs is significant. Defence has an opportunity to create a pipeline of well-trained peer workers who retain their skills with refresher courses over the course of their career and into their post-service lives.
148. A further advantage of a mental health-trained peer workforce is that it can go a long way to reducing stigma around mental health and make a significant difference to organisational culture. As Australian mental health training organisation Blooming Minds puts it:

developing a culture of peer support build[s] the capacity within the organisation to reduce future risks and increase current responsiveness to mental well being ... create[s] a culture of ‘this is how we do things around here’ ... [and] embed[s] proactive processes ... so that the organisation is focused on the wellbeing of all rather than addressing an isolated incident of crisis or risk.¹³²

149. Strategies to address workforce issues and waiting times must be an area of focus for Defence. As we've said above, access to timely health care can be protective against suicide and suicidality.

16.3.3 Continuity of care is lacking

150. Continuity of care is 'the degree to which a series of discrete healthcare events is experienced by the patient as coherent and connected and consistent with the patient's medical needs and personal context'.¹³³ Three ways of giving patients continuity of care are by having one clinician acting as a single point of care, by ensuring excellent coordination between different clinicians providing care and by having effective clinical handover between clinicians.
151. Continuity of care is associated with increased patient satisfaction, increased take up of health promotion, greater adherence to medical advice and decreased use of hospital services.¹³⁴ Conversely, when there is an absence of continuity of care, patient outcomes can be significantly undermined.
152. Professor Helen Milroy, a child and adolescent psychiatrist, gave evidence summing up the importance of continuity of care in the context of mental health care:

One of the things we probably still have ... is this fragmentation of care and people falling between gaps. Who is going to take overall responsibility to make sure [patients] navigate the system in a way that's helpful and actually achieves the outcomes that we want? ... [F]ragmentation of care is never helpful in a mental health context.¹³⁵

153. While the ADF healthcare system has some processes in place that aim towards continuity of care, some ADF members have told us that the implementation of these processes is far from effective.¹³⁶ For example, one member with over 30 years of experience stated:

And so, this is the way of the ADF's medical system. No continuity of care. Ever-changing [medical officers]. No review of your records as you move from one facility to another. Uniformed and Contractor staff at odds with each other in the workplace. A dysfunctional electronic medical records management system. A culture that, for the first 15 years of my career at least, discouraged seeking medical support or assistance and – when you did – often chose to ignore the medical advice provided by the doctor or medic anyway, guilt-tripping the soldier for being 'a malingerer'.¹³⁷

154. Rear Admiral Sarah Sharkey, former Surgeon General of the ADF and former Commander of Joint Health Command, gave evidence that she did not have any measure or metric for looking at continuity of care in any way.¹³⁸ This is not consistent with good clinical governance.

155. We heard of three contexts within service life at which clinical care of ADF members is handed over:
- (1) Garrison health care, by its nature, involves a range of healthcare providers, meaning that effective clinical handover must be built into the system.
 - (2) Posting and deployments involve clinical handover as members are posted to new locations and are deployed and return from deployment.
 - (3) Members separating from the ADF transition from ADF healthcare providers to the civilian healthcare sector, necessitating a complex coordination and handover which we have heard has not historically been well handled. (We address this issue in Chapter 18, Health care for ex-serving members, and Chapter 23, Transition from military to civilian life.)
156. When these are not well managed, the resulting *discontinuity* of care can significantly reduce the member's trust in the healthcare system and their sense of being genuinely looked after, as they should rightfully expect. It reduces the overall quality of ADF members' health care, regardless of the skills and expertise of any single clinician.

Continuity of care within garrison health settings

157. In garrison settings, continuity of care can be undermined by staff shortages, the centralisation of uniformed clinicians under Joint Health Command, and the outsourcing of service delivery to contracted health providers.
158. It is well known that 'relational continuity', where there is an ongoing relationship between a patient and a single clinician, generates clinical benefits. On the one hand, it facilitates the development of trust and knowledge between the patient and clinician, and on the other hand, in the context of a longer relationship, clinicians tend to feel more empowered to provide long-term and preventative care.¹³⁹
159. However, under the garrison health system, members cannot be guaranteed continuity with a single practitioner over successive visits. ADF members can only choose their clinician within the constraints of availability, and may not get to choose at all.¹⁴⁰
160. As a result, members may consult with many health professionals while being treated for a given concern. Numerous members spoke of the added stress of having to provide the same information repeatedly, which is sometimes distressing in its own right, to different health professionals. They reported that relevant information was not always communicated to a new treating practitioner. Some attributed this to staff shortages, while others attributed it to the records system.¹⁴¹
161. From the patient's perspective, lack of continuity of care can be a barrier to help seeking. Padre Gary Stone, a former Army member and chaplain, said, '[y]ou can't just go to ... the Bupa guy who just got off the boat yesterday and put him here this week and next week there will be a different guy'.¹⁴²

162. Clinicians have also raised their concerns with us about Defence health systems not supporting continuity of care. Dr Worswick, for example, said that treating clinicians who are not able to build up relational continuity can become ‘lost in the here and now’, not able to look at the long-term health of the member despite providing effective clinical care in the moment.¹⁴³
163. Dr Worswick spoke of the importance of continuity of care not just for the patient, but also for the occupational side of ADF health care, whereby commanding officers must make decisions about members’ employability and deployability.¹⁴⁴

Current data and records management systems can impede continuity of care

164. The Defence electronic Health System (DeHS) was introduced in 2014 and was Australia’s first national e-health system. According to Defence, it has delivered significant benefits but ‘no longer meets Defence’s contemporary and future requirements’.¹⁴⁵
165. DeHS is unable to exchange information with other Commonwealth agencies, cannot be deployed, and does not provide functionality for the management of inpatient care, emergency triage or first responder health activities.¹⁴⁶ We do, however, note that garrison healthcare staff can manually upload clinical information provided by off-base service providers.¹⁴⁷
166. These limitations reduce Defence’s system capacity to deliver continuity of health care.
167. We are aware that Defence is developing and implementing a new Health Knowledge Management System to replace DeHS.¹⁴⁸ We are told that the new system will be significantly more advanced than DeHS and will span health care in garrison and on deployment, thus better facilitating continuity of care.¹⁴⁹
168. We support this capability of the new system and also suggest that Defence explore using My Health Record to support continuity of care.
169. Under the *My Health Records Act 2012* (Cth), information contained in a My Health Record cannot be used for ‘employing, or continuing or ceasing to employ, a healthcare recipient’. Because Defence is an employer, this limits the ability of Defence clinicians to access a member’s My Health Record or input into it.
170. In September 2020, Joint Health Command made a submission during a review of the Act requesting legislative amendment to allow Defence access to My Health Record for healthcare purposes only.¹⁵⁰ To our knowledge, this has not been implemented, but we would support it being given further consideration.

16.3.4 Rehabilitation is vital

171. The ADF Rehabilitation program has been developed to assist members to return to a state of individual readiness as soon as is practicable after injury or illness.¹⁵¹ Safe and effective rehabilitation programs are particularly important in the ADF, given high injury rates and the flow-on risks of medical discharge and suicide and suicidality.
172. It is crucial that ADF members are properly supported in returning to work from injury and illness. The Royal Australasian College of Physicians' position statement, 'Helping people to return to work', says that being out from work for an extended period of time has negative health consequences, and the longer someone is away from work, the less likely they are to return.¹⁵²
173. The length of time off work and the likelihood of returning can be expressed as:
- after 20 days off work, the chance of returning to work is 70%
 - after 45 days off work, that probability is reduced to 50%
 - after 70 days off work, it is reduced to 35%.¹⁵³
174. When an injured or ill employee can continue to work in some capacity, they should. It promotes quicker recovery. The Royal Australasian College of Physicians contends that while some work absence might be medically required, the primary focus of rehabilitation (and best practice) should be the employee's return to work.¹⁵⁴ This may necessitate appropriate accommodations made by their employer in some cases.¹⁵⁵
175. We agree with this advice and explore this topic in greater detail in Chapter 5, The military employment classification system and medical separation, where we recommend that Defence implement measures to increase employment opportunities within the ADF for members who are no longer able to be deployed due to illness or injury.

Some Defence rehabilitation programs appear substandard

176. Throughout our inquiry, the quality of rehabilitation services has been brought into question. A current physiotherapist in the ADF made an anonymous submission to the Royal Commission in which they detailed the following claims regarding unsafe and inadequate treatment of rehabilitating members:

I have repeatedly observed poor healthcare practices that go against current medical evidence and models of best practice by both doctors and physios in the [-] Health Centre. I believe this is contributing to poor healthcare treatment outcomes and leading to medical discharges that may have been avoidable ... [including] inadequately loading patients [with heavy packs and equipment] and then returning members to running too soon ... [resulting] in the member re-rupturing their ACL.

The current model of care within the physio department at [-] Barracks allocates time to patient treatment only. The physio manager has stopped staff attending unit welfare boards and meetings with rehab consultants as this is seen as a poor use of time ... Not having a physio present at the unit welfare boards has led to units getting members to do inappropriate tasks in the workplace and being sent away on exercise when it was not in the best interest of the member.

[T]here is no physio supervision of the physio rehab sessions [despite the fact that these are sessions] in which the physio is supposed to provide the member with a gym-based program to complete independently. It is unacceptable that members [are] undertaking rehabilitation without any direct supervision and that this is considered 'physio rehab'.¹⁵⁶

177. The issues raised by this health professional are extremely concerning. It is not difficult to think of several good reasons why the rehabilitation services provided by Defence should be of the highest quality. Particularly, with our focus on suicide prevention, successful rehabilitation of ill or injured members is likely to go a long way in reducing risk factors for suicide and suicidality, including medical discharge.
178. Defence measures rehabilitation outcomes via a 'return-to-duty' rate. According to Defence, this is a military-specific measure that is linked to a member's MEC and is measured 12 months after their rehabilitation program finishes.¹⁵⁷
179. The most recent data Defence provided on return to duty is from 2021–22. Then, the return-to-duty rate was 36.4% for the Navy, 38.2% for the Army and 42.1% for the Air Force.¹⁵⁸
180. We are constrained in our ability to judge what these rates say about the effectiveness of ADF rehabilitation programs because the Defence context is not easily comparable to other sectors. Additionally, we have not been able to benchmark the rates against defence forces in other jurisdictions. We strongly suggest that this is something Defence ought to do.

Rehabilitation units do not appear to be effectively returning injured members to duty

181. As we mentioned earlier in the chapter, Defence has a number of units that, according to Defence, provide additional support to members undertaking a rehabilitation program. Mostly, these units require the member to spend time away from their usual location, their usual peer group and their usual role.
182. While we understand the rationale of creating rehabilitation units that operate in this way, we are very concerned about the social isolation and other risk factors that arise when the member is separated from their home unit.
183. The interim National Commissioner for Defence and Veteran Suicide Prevention, Dr Bernadette Boss CSC, reported on the roundtable discussions she had with organisations representing ADF members and veterans. Dr Boss said she heard

from ex-serving members who said that designated rehabilitation units were akin to 'holding units' with members feeling ostracised and isolated from their 'Defence family'.¹⁵⁹ As we discuss in Chapter 1, Understanding suicide, these feelings are both risk factors for suicide and suicidality.

184. She also reported anecdotal evidence that the leaders of these units are often assigned these roles due to under-performance, contributing to a culture and an atmosphere that is not conducive to recovery.¹⁶⁰ Additionally, she heard that members had little to nothing to do all day, and that there was little or no investment in genuine rehabilitation.¹⁶¹ We heard other similar accounts.

185. One former serving member made a submission about his experience with rehabilitation in the ADF. He said:

I have found the organisation to be too risk-averse when dealing with individuals with mental health. Instead of talking to an individual and creating a work plan, we just remove work away from an individual or give them work that [is] so mundane that they spiral into thinking they are undervalued and unappreciated.¹⁶²

186. He went on to talk about the need to create:

a more comprehensive command course that educates on better ways of management of mental health, to give managers a better understanding on what an individual goes through, as well as challenging an individual and creating self-worth in both themselves and the organisation.¹⁶³

187. We asked Defence to provide data on the number of members who are posted to a rehabilitation unit and go on to be involuntarily separated from Defence. The Royal Commission's analysis of the data indicates that, of the members posted to either a soldier recovery unit or the Trainee Rehabilitation Wing between 2017–18 and 2021–22, 47% were involuntarily separated.¹⁶⁴

188. Similarly, 42% of members who were posted to a personnel support unit between 2017–18 and 2021–22 were involuntarily separated.¹⁶⁵

189. Again, without the ability to benchmark this data, we are limited in what inferences we can draw from it. However, given that members who separate involuntarily are at increased risk of suicide and suicidality, we suggest that a lower rate of separation would be desirable and wonder whether, under different circumstances, the members posted to these off-base centres might have had an avenue to stay in service if that had been their wish.

190. Effective rehabilitation is critical for recovery from illness and injury, and restoring quality of life. We think Defence should be doing more to ensure that its rehabilitation programs are best practice and in the best interests of members. We are not confident that this is the case, given the lack of transparency around outcomes, as we discuss later in this section.

Lack of reporting and monitoring of rehabilitation outcomes

191. In 2019, the Productivity Commission review identified a lack of monitoring and reporting on rehabilitation outcomes.¹⁶⁶ In the course of our inquiry, we have come to the same conclusion.
192. Data reported is limited to return-to-duty rates.¹⁶⁷ In our view, this does not provide a full picture of the quality and effectiveness of rehabilitation programs. This lack of transparency also means there is little accountability for those leading and managing rehabilitation services.
193. In 2019, the Productivity Commission recommended that Defence report 'more extensively' on the outcomes of its occupational rehabilitation program in the Joint Health Command Annual Review.¹⁶⁸ The Commonwealth gave evidence that it had accepted and implemented this recommendation.¹⁶⁹ However, not only did Defence not increase its reporting on rehabilitation outcomes, Defence stopped publishing the Joint Health Command Annual Review in 2019 altogether.¹⁷⁰
194. We are unaware of the formal reporting of any rehabilitation outcomes other than the return-to-duty rate, which is published in the ADF Annual Report.¹⁷¹ We think this should be rectified and a wider range of outcomes reported. This would go some way to improving transparency and, therefore, accountability for ADF rehabilitation programs. Far from being a peripheral issue, the quality of rehabilitation services in the ADF must be understood as part of a broad strategy for suicide prevention.

Recommendation 66: Where possible, support injured members to be rehabilitated at work, within their home unit

The Australian Defence Force (ADF) should support and resource rehabilitation services within the ADF to adopt a tailored approach, from members rehabilitating within their home unit, either with or without the support of a specialist rehabilitation service working in conjunction with the chain of command when required, to coordination of rehabilitation and recovery through a specialist rehabilitation unit only in exceptional circumstances and when necessary to optimise functioning and return to work.

Consistent with this approach:

- (a) Defence policies and procedures related to rehabilitation should adopt the principle of recovering at work, where safe to do so. This principle should be embedded in the Defence Health Manual, Military Personnel Manual, ADF Rehabilitation Program Procedures Manual, and other relevant policies and guidelines.
- (b) rehabilitation at home or in a designated rehabilitation unit should be reserved for exceptional circumstances, and even in these instances, home units must maintain connection with the member undergoing rehabilitation, whether that be at home or assigned to a designated rehabilitation unit
- (c) rehabilitation outcomes should be publicly reported on a regular basis.

16.4 Opportunities for improvement

195. As we have stressed throughout this chapter, timely, accessible and quality healthcare and rehabilitation are critical for reducing risk factors linked to suicide and suicidality. Unfortunately, based on the evidence we have heard, Defence is not always performing well in this regard.
196. In this section, we make recommendations and identify areas for further exploration to rectify what we see as systemic issues.

16.4.1 Could health and wellbeing support be embedded?

197. The decision to centralise health services in 2008 seems to us to be a logical decision in reducing complexity and duplication, and improving consistency across the services.
198. However, it is possible that some of the issues identified in this chapter risk being exacerbated by the centralisation and contracting out of health services, if effective controls are not in place. These issues include:
- clinicians' lack of occupational understanding of ADF service
 - lack of continuity of care
 - the delivery of rehabilitation programs separate from a member's home unit leading to social isolation and high numbers of involuntary separations.
199. Significantly, Lieutenant General Simon Stuart AO DSC, now Chief of Army, submitted evidence to this Royal Commission that health and wellbeing support needs to be provided at the 'point of need' to improve the health and wellbeing of members, and improve the operational effectiveness of teams.¹⁷²
200. He suggested having a dedicated health and wellbeing 'capability brick' (team) at the unit level:

Delivering this sort of capability brick approach at the unit level is, in my experience and my opinion, the most effective place to deliver it for a couple of reasons: firstly, we expect to hold commanders at the unit level accountable for [the] health and wellbeing of their people. If I want to hold someone accountable for a task, then I need to resource them to be able to execute that task.¹⁷³

201. Lieutenant General Stuart, in his statement to the Royal Commission, fleshed out his proposal for embedded health and wellbeing teams, saying:

The Health and Wellbeing team would ideally reflect a multidisciplinary model and include medical (doctor, nurse, medic), allied health (physiotherapist, psychologist, physical training instructor), pastoral care (family engagement and support, padre, social worker), and command, leadership and management

(command team, data manager, administrator, trainer, integrator). The density of skills would depend upon the type of unit, its size and demography. Teams would be scalable and modular.¹⁷⁴

202. Throughout our inquiry, we have heard that multidisciplinary care represents best practice.¹⁷⁵ This is particularly relevant given that the needs and comorbidities of serving members are often complex.
203. We have also heard evidence of barriers to help seeking. Additionally, we have heard reflections from current and former uniformed medical practitioners that centralising health services, and the increased use of contractors, dilutes military awareness and occupational understanding of ADF service, reduces continuity of care and makes it harder to foster integrated feedback loops with command.¹⁷⁶
204. Defence advised us that Commodore Paul Kinghorne RAN undertook a review of ADF health services in 2012,¹⁷⁷ the same year that the ADF Health Services Contract commenced. We have not seen any evidence of an evaluation of health services delivery since 2012, and believe a review is warranted given the changes that have taken place.
205. We note the Joint Health Command Functional Review in 2021.¹⁷⁸ However, the remit of this review was limited to Joint Health Command and whether it was adequately governed, structured and resourced to allow it to implement the ADF Health Strategy.¹⁷⁹
206. We think there could be merit in reviewing the current arrangements for delivering health services and support to explore whether greater unit-based support would be desirable and feasible.
207. We think a model like the 'capability brick' proposed by Lieutenant General Stuart could potentially supplement the current model of garrison health services centralised through Joint Health Command.
208. At the same time, Defence should consider whether it has the right mix of uniformed, APS and contracted health professionals. This is particularly relevant in the context of the issues already raised in this chapter (and elsewhere in the report) in relation to military cultural competency and occupational understanding of ADF service.
209. In doing so, consideration should be given to whether the right incentives are in place to attract and maintain sufficient uniformed health workers now and into the future.

16.4.2 Strengthening clinical governance

210. We think a strong clinical governance framework would go a long way to addressing the issues we have identified throughout this chapter.
211. This includes ensuring clear and cooperative governance and leadership, and that the workforce has the right qualifications, skills and training to provide safe and high-quality care to patients.

212. A well-functioning clinical governance system:

- monitors clinical performance and effectiveness
- has robust and effective quality improvement systems
- supports an environment that promotes safe, high-quality health care
- takes a systematic approach to collaborating with consumers and other partners in the delivery of health care.

213. Defence told us that the Surgeon General of the ADF commissioned a review of the clinical governance systems in the second quarter of 2024. This work is expected to progress through the 2024–25 financial year, and according to Defence, '[t]he outcomes of this review will ensure alignment with national guidelines, standards and benchmarks in the Defence context'.¹⁸⁰

214. We agree there is a need for Defence to review its framework for clinical governance. In the following sections we outline the issues that we have identified, which should be considered as part of the review.

Defence's Clinical Governance Framework

215. The Defence Clinical Governance Framework is defined in the Defence Health Manual.¹⁸¹ Approved in 2011, it was developed 'with reference to civilian best practice systems at the time'.¹⁸²

216. We have reviewed Volume 2, Part 1, Chapter 4 of the Defence Health Manual, which is titled 'Clinical Governance Framework'. We find it lacking when compared to the National Model Clinical Governance Framework, developed by the Australian Commission on Safety and Quality in Health Care.¹⁸³

217. Currently, the Defence Health Manual has only four pages (out of over 2,500) on the Clinical Governance Framework (though we recognise that components of clinical governance may be included in other chapters of the manual).

218. However, for due emphasis and clarity, we think the key components of Defence's Clinical Governance Framework should be more accessible and be set out in more detail, including the actions and allocation of responsibilities for each of the key components.

219. We accept that the National Model Clinical Governance Framework has been designed for the acute care sector and with civilian health organisations in mind. However, our view is that the five components, which are described further in Chapter 14, Introduction to health care for members and veterans, are equally applicable to ADF health services.

220. We would encourage Defence to review its existing Clinical Governance Framework with a view to aligning it with the National Model Clinical Governance Framework.

- 221. Defence should do this in partnership with relevant expert bodies such as the Australian Commission on Safety and Quality in Health Care, and in consultation with partner health service organisations (including Bupa and DVA) and consumers.
- 222. In undertaking the review, Defence should consider all five of the key components of clinical governance in the National Model Clinical Governance Framework.
- 223. In particular, we wish to draw attention to the opportunity for Defence to strengthen its performance monitoring and quality improvement systems, which are discussed in the following section.

An increased focus on performance monitoring and quality improvement

- 224. Throughout our inquiry, we have observed the need for improved performance monitoring and continuous improvement, as well as greater reporting for transparency and accountability. This is also true in the case of Defence and veteran health care.
- 225. Regular feedback and review of healthcare systems and processes are critical to ensuring that these systems continue to be effective and meet the needs of patients and other partners.
- 226. Patient safety and quality improvement must be audited, preferably by an external body. Audits must be supported by high-quality, relevant data to assess performance against agreed standards and indicators.
- 227. Defence told us that the performance of ADF health services is ‘monitored, assessed and reported against on a regular basis through numerous mechanisms, including the Defence Corporate Plan and the Defence Enterprise Committees Framework’.¹⁸⁴
- 228. Specifically, the Garrison Health Service Delivery Working Group monitors and measures the performance of the delivery of health care to members within the garrison environment.
- 229. According to Defence, the working group monitors key performance measures including timeliness of access to care, individual health readiness of members, capacity of the health system, workforce levels and notices of changes to activity level and demand.¹⁸⁵
- 230. While these are important, we note that they are process measures as opposed to measures of clinical effectiveness and outcomes.
- 231. We asked Defence what measures and metrics are used to assess outcomes of care. In response, Defence advised that ‘outcomes of care are measured through a range of metrics that monitor the health of the force’.¹⁸⁶

232. It appears that the 'health fitness' of defence members is used as a proxy for outcomes of care.¹⁸⁷ Defence measures health fitness by determining:

- The allocation of individual military employment classification
- Return to duty measures as an outcome of the ADF rehabilitation program
- Periodic dental examination and allocation of dental fitness category
- Currency of vaccination
- Measures of population health in line with the [Royal Australian College of General Practitioners] red book
- Review and analysis of low value care, including unnecessary surgery and inappropriate use of antibiotics
- Occupational health screening outcomes.¹⁸⁸

233. We are not satisfied that these measures are adequate for assessing outcomes of care, and it would seem that Defence agrees. In response to our request for information, Defence said:

Like all health systems, Defence is aspiring to create better health outcome measures that reflect contemporary health system measurements beyond inputs and outputs.

234. Defence told us that specific areas for 'ongoing accountability' will include:

measured, outcome-based clinical standards improvement, implementation of any findings of the [clinical governance review], and evaluation of the impact of all of those changes.¹⁸⁹

235. In addition, Defence said:

Clinical assurance including clinical outcomes reporting frameworks will be strengthened by the newly created and appointed position of Deputy Surgeon General ADF who will be the executive lead on clinical assurance.¹⁹⁰

236. We welcome these developments in response to the propositions we put forward to Defence about the adequacy of its approach to clinical governance.¹⁹¹

Standards for quality and safety in health care

237. During our final hearing block in March 2024, Commissioner Brown asked Rear Admiral Sarah Sharkey AM CSC RAN and Rear Admiral Sonya Bennett AM RAN about standards for Defence health services and whether they undergo any formal accreditation process.¹⁹²

238. Rear Admiral Bennett said that her team ‘are alert to the national standards out there and continue to keep abreast of how we are mapping across [them]’.¹⁹³ She went on to say that ‘a lot of them aren’t entirely relevant to Defence because they’re around acute care’.¹⁹⁴
239. Rear Admiral Sharkey confirmed that Defence health services are not subject to any formal or external accreditation processes.¹⁹⁵ We understand this to be the case for assessing performance against both clinical care standards and health service standards.
240. We believe that clearly defined health service standards and clinical care standards are necessary and would be of benefit, as would a formal accreditation process to drive quality improvement and accountability.
241. In relation to health service standards, there are existing garrison health service standards, which are based on the Royal Australian College of General Practitioners’ Standards. They were published in 2015.¹⁹⁶ More recently, in 2021, the Australian Commission on Safety and Quality in Health Care published the National Safety and Quality Primary and Community Healthcare Standards.¹⁹⁷
242. We think there would be merit in Defence reviewing the more recent Australian Commission on Safety and Quality in Health Care standards as part of a process to update the existing garrison health standards. This should occur in partnership with the Australian Commission on Safety and Quality in Health Care and the Royal Australian College of General Practitioners.
243. For the most part, we believe Defence could rely on existing clinical care standards, such as those developed by the Australian Commission on Safety and Quality in Health Care.
244. Where there are gaps, additional standards could be developed that focus on the highest-priority concerns within the Defence context. They should be informed by quality research and best-practice models of care and developed by expert bodies in consultation with Defence.
245. Whether Defence has achieved health service standards and clinical standards could then be assessed through better performance monitoring systems and formal accreditation.
246. This work aligns with the need we have also identified for Defence to strengthen its clinical governance framework.
247. We have stressed the importance of strong clinical governance for high-quality, safe healthcare services. Performance monitoring, as well as the articulation of clear and consistent standards and indicators for measuring those standards, is therefore absolutely critical.
248. We urge Defence to further consider its clinical governance framework and improve its performance monitoring to ensure continuous improvement and optimal patient care.

Recommendation 67: Align Defence's clinical governance framework with the national model framework

Defence should work with relevant bodies, including the Australian Commission on Safety and Quality in Health Care and the Royal Australian College of General Practitioners, and in consultation with Bupa, the Department of Veterans' Affairs (DVA) and relevant civilian health services to review its clinical governance framework, with a view to aligning it with the National Model Clinical Governance Framework.

Defence should give particular attention to:

- (a) strengthening its quality improvement systems to actively manage and improve the safety and quality of its health care
- (b) ensuring that performance monitoring systems are in place to monitor clinical effectiveness
- (c) establishing partnerships across DVA, civilian healthcare services and specialist facilities for serving and ex-serving members, and leveraging these partnerships to respond optimally to the unique needs of each patient
- (d) ensuring that serving members are a partner in the design, delivery and evaluation of Australian Defence Force healthcare services.

16.4.3 Getting privacy and information-sharing settings right

249. Members' right to privacy and confidentiality of personal information is in tension with the sharing of information appropriate to their health needs and, in some instances, to protect their safety, as well as the operational needs of the organisation that employs them.
250. During our inquiry, the mandate to protect members' privacy has been spoken of as a barrier to providing family members and commanders with the information they need to best support members experiencing psychological distress and mental ill health. We have also heard that 'privacy' is a barrier to proactively connecting veterans with appropriate support.¹⁹⁸
251. Members raised concerns that their personal information (particularly health information) was shared inappropriately within Defence and we heard that some members did not trust Defence to keep their personal information private and confidential.¹⁹⁹

252. Somewhat paradoxically, we also heard that commanders with operational responsibility for the safety and wellbeing of members did not always have access to members' personal information because of privacy.²⁰⁰ This makes it very difficult for them 'to understand an individual's circumstances, assess risk, and facilitate appropriate support requirements'.²⁰¹
253. Families shared their heartache and anger that Defence had not provided them with the health information of loved ones who had experienced mental health crisis.²⁰² We also heard that some families were not told of a loved one's suicide attempts until after their death by suicide.²⁰³ As one submission author wrote:
- If we had known, we could have made all possible efforts to assist him overcome suicidal thoughts and address the issues causing these.²⁰⁴
254. Within Defence, privacy considerations have been perceived as a barrier to sharing health information for some time.²⁰⁵ As at 26 March 2024, the Secretary of Defence, Mr Greg Moriarty AO, believed privacy and consent 'remains a real challenge' for Defence.²⁰⁶
255. In our view, the *Privacy Act 1988* (Cth) is not necessarily a barrier to sharing certain aspects of health information to facilitate appropriate care and support, when the individual is distressed or experiencing acute mental ill health. We acknowledge that each situation will be context-specific and, importantly, action must be informed by the wishes of the serving or ex-serving member.
256. It is essential that members and veterans understand how the Privacy Act operates, and are consulted to obtain their consent to share their health information in the event they are distressed or experiencing mental ill health. This is critical for ensuring that those able to facilitate care and support – particularly family members, commanders and veteran support services – are in a position to do so.
257. We have also identified issues with Defence's own *Defence Privacy Policy*. In our view, there are parts of the policy that do not clearly set out its operation and application (discussed later in this section). The policy should be reviewed as a priority, and amended as appropriate. It should also be subject to regular review.
258. In Chapter 18, Health care for ex-serving members, we recommend that DVA seek legal advice to clarify the application of the Privacy Act (and other relevant legislation) to ex-serving members and their families (Recommendation 74). If legislative barriers remain following review and amendment of the *Defence Privacy Policy* as referred to above, then consideration could be given to subsequent legislative change, as part of the process set out in Chapter 18.

The Privacy Act is not necessarily a barrier

259. To understand whether members' 'privacy' is an absolute barrier to information sharing, it is necessary to briefly outline how the *Privacy Act 1988* (Cth) operates. This is important because there is no common law right to privacy in Australia.²⁰⁷

260. The Department of Defence and the Department of Veterans' Affairs (DVA) are both 'agencies' under the Privacy Act and are therefore required to comply with that Act.²⁰⁸

261. However, the Privacy Act does 'not confer a right to privacy as such'.²⁰⁹ Rather, it:

reflects the Parliament's concern to recognise and protect individual privacy within the framework of a complex statutory regime.²¹⁰

262. It does this through:

a series of statutory provisions which protect the privacy of individuals from unlawful or arbitrary interference but also by specifying circumstances (or 'exceptions') which reflect the Parliament's concern to strike an appropriate balance between competing community interests.²¹¹

263. That is, while the Privacy Act protects the 'personal information' of serving or ex-serving members, that protection is not absolute but subject to certain exceptions, which reflect competing community interests.

264. One of those interests that is particularly relevant to the work of this Royal Commission, is where the disclosure of personal information is necessary to lessen or prevent a serious threat to the life, health or safety of an individual.²¹²

265. Furthermore, the concept of 'personal information' is 'very broad'.²¹³ The Privacy Act defines it to mean:

information or an opinion about an identified individual, or an individual who is reasonably identifiable:

whether the information or opinion is true or not; and

whether the information or opinion is recorded in a material form or not.²¹⁴

266. The Privacy Act does not protect the personal information of a deceased individual. This is reflected in the Australian Privacy Principle Guidelines published by the Office of the Australian Information Commissioner.²¹⁵

267. There are 13 Australian Privacy Principles (APPs) which regulate the handling of personal information.²¹⁶ Relevantly, an 'act or practice that breaches an Australian Privacy Principle in relation to personal information about the individual'²¹⁷ constitutes an interference with a person's privacy.²¹⁸

268. Of most relevance to the concerns raised during this inquiry are:

- APP 1 – open and transparent management of personal information
- APP 3 – collection of solicited personal information
- APP 6 – use or disclosure of personal information.

APP 1 – Open and transparent management of personal information

269. Under APP 1.2(a), Defence must take such steps as are reasonable in the circumstances to implement practices, procedures and systems relating to Defence's functions and activities that will ensure that Defence complies with the APPs.²¹⁹

We note that these obligations apply to both Defence and DVA, though for the sake of simplicity, we refer to 'Defence'.

270. Notably, Defence must have a 'clearly expressed and up-to-date policy' about the management of personal information (APP 1.3). It must include:

- the kinds of personal information Defence holds and collects
- how Defence holds and collects personal information
- the purposes for which Defence collects, holds, uses and discloses personal information (APP 1.4).²²⁰

271. Importantly, as Australian Information Commissioner Angelene Falk outlined, the Privacy Act:

is a principles-based law and incorporates a number of concepts such as the taking of reasonable steps and that **allows each Government agency to create the processes and practices to comply with the Act that are appropriate to their particular context.**²²¹

272. It is therefore essential that the processes and practices of Defence and DVA are appropriate to their specific contexts.

APP 3 – collection of solicited personal information

273. Defence must not collect personal information (other than sensitive information) unless the information is reasonably necessary for, or directly related to, one or more of Defence's functions and activities (APP 3.1).²²²

274. Defence must not collect *sensitive information* – which includes health information²²³ – unless:

- the individual consents and the information is reasonably necessary for, or directly related to, one or more of Defence's functions and activities (APP 3.3(a)(i))
- the collection is required by law or a court/tribunal order (APP 3.4(a))
- a 'permitted general situation' exists (APP 3.4(b)).²²⁴

275. When Defence collects personal information about an individual, it must take reasonable steps to notify the individual or ensure the individual is aware of the purposes for which it collects the information (APP 5.1, 5.2(d)).²²⁵

APP 6 – Use and disclosure of personal information

276. The Privacy Act ‘primarily starts from the proposition that an agency collects information for a primary purpose and it shouldn’t disclose that information for a secondary purpose unless certain circumstances apply’.²²⁶ ‘Disclosure’ is ‘when a government agency releases from its effective control information in its possession’.²²⁷

277. Relevantly, the circumstances for disclosure include where:

- consent is obtained from an individual (APP 6.1(a))
- a ‘permitted general situation’ exists (APP 6.2(c))
- the individual would reasonably expect the use or disclosure where the disclosure is related or directly related (for sensitive information) to the purpose of collecting that information (APP 6.2(a)) or
- the disclosure is required by law or a court/tribunal order (APP 6.2(b)).²²⁸

278. Australian Information Commissioner, Ms Angelene Falk, gave evidence that a ‘better practice’ approach is to:

have the processes and policies in place **that set out clearly** when each of those circumstances will apply **in the agency’s context**.²²⁹

279. Of most relevance to the Royal Commission’s work are the points ‘where consent is obtained from an individual’ and where a ‘permitted general situation’ exists. We consider each of these in turn.

Where consent is obtained

280. It is apparent from APP 3.3(a)(i) and APP 6.1(a) that an individual’s consent is a key mechanism to facilitate information sharing and, critically, sharing of their health information.

281. In our view, consent is the simplest and most pragmatic way to ensure that key stakeholders can facilitate appropriate care and support for members experiencing distress and mental health crisis. These would typically include family members, commanders and delegates of veteran support services.

282. There are four elements of consent:

- the individual is adequately informed before giving consent
- the individual gives consent voluntarily
- the consent is current and specific
- the individual has the capacity to understand and communicate their consent.²³⁰

283. In our view, whether a member is ‘adequately informed’ before giving consent to the sharing of their health information and whether consent is ‘specific’ depends on what they are told about why their health information is collected, who their information will be disclosed to, and why.

284. In this regard, the *Defence Privacy Policy* states:

We may collect sensitive information about you where you consent, the collection is allowed under the Privacy Act or when the collection is authorised or required by law.²³¹

285. The circumstances in which the Privacy Act allows Defence to collect health information (sensitive information) is set out above. In short, the health information needs to be reasonably necessary for, or directly related to, one or more of Defence’s functions and activities (and the individual consents); it must be required by law; or a ‘general permitted situation’ must exist.

286. As to why Defence collect, holds, uses and discloses personal information, the *Defence Privacy Policy* refers to the legislative and functional responsibility of the Minister for Defence and the Department and states:

In order to satisfy these responsibilities and Defence’s responsibilities under the various pieces of legislation it administers, Defence collects personal information for various purposes depending on the individual’s relationship with Defence. Generally, Defence collects personal information for the following purposes:

- the recruitment, enlistment, appointment, command, administration, management and discipline of ADF members
- ...
- the provision of health, rehabilitation and veterans’ services to Defence personnel
- the management of the welfare of Defence personnel and their dependants
- ...
- the conduct of Defence business activities with the individual
- ...
- compiling diagnostic information.²³²

287. In our view, the *Defence Privacy Policy* does not clearly set out:

- how members' health information is reasonably necessary for, or directly relates to, the functions and activities listed
- whether (and if so, how) the collection is required by law
- when a 'general permitted situation' exists.

288. These matters should be clarified to give members greater confidence that their personal information will be dealt with strictly in accordance with the Privacy Act. This may, in turn, encourage members to provide fuller and more accurate clinical histories. It would give them the opportunity to consent to how their health information will be used and disclosed.

289. As Defence recognises, their failure 'to protect Defence members' health information may result in [their] reluctance ... to provide full and accurate clinical histories or even attend for care'.²³³

Disclosure of health information to commanders

290. The centrality of consent is reflected in the *Defence Privacy Policy* in relation to how Defence discloses health information:

Defence does not disclose personal health information to **any** other person, **including next of kin**, unless the individual about whom the information relates **has given express consent**, or the disclosure is **required or authorised by or under Australian law**, or in circumstances where it is **unreasonable to obtain the individual's consent and the disclosure is necessary to lessen or prevent a serious threat to life, health or safety of an individual or to public health and safety**.²³⁴

291. In our view, the *Defence Privacy Policy* does not make it clear when a member's health information will be disclosed to commanders or managers, or when, if consent hasn't been granted, a member's health information will be disclosed to their next of kin.

292. We note that the Privacy Notice in the Form PM165 'Health questionnaire' used in recruitment directs the member back to the *Defence Privacy Policy* for information about the way Defence collects and discloses personal information.²³⁵

293. Greater detail as to the purpose of collecting members' health information and how it will be used and disclosed is found in the Defence Health Manual. However, that document is long and complex and is not referred to in the *Defence Privacy Policy*.

294. The Defence Health Manual refers to regulation 49 of the *Defence Regulation 2016* (Cth) which 'requires Defence to arrange for the provision of medical and dental treatment necessary to keep a Defence member fit for the performance of the member's duties'.²³⁶ To this end, the Defence Health Manual explains that:

Defence health practitioners collect health information to manage, diagnose and treat an individual's health on an ongoing basis; **to advise commanders and managers of Defence members' and Defence candidates' suitability for service from a health perspective**; and to provide documentary evidence of the health preparedness of an individual for military operations.²³⁷

Defence health practitioners are to provide commanders and managers with information relating to the occupational and operational fitness of Defence members under command or line of management. This disclosure is **only for the purpose of meeting the commander or manager's duty of care and work, health and safety obligations**.²³⁸

295. It is not clear what 'suitability for service from a health perspective' means. Specifically, it is not clear what factors are relevant to a health practitioner deciding when to advise a commander of a member who was experiencing distress or mental ill health.
296. We acknowledge that commanders and managers 'have a duty of care for the well-being of Defence members under their command or supervision' and are 'responsible for conducting appropriate workplace risk assessments and taking all reasonably practicable steps for the control of likely threats to health'.²³⁹
297. In our view, to better facilitate appropriate support for members experiencing distress or symptoms of mental ill health, it should be clarified whether 'suitability for service from a health perspective' includes the wellbeing of Defence members, and in any event clarifying when members' mental health information will be disclosed to commanders to support the Defence member's wellbeing.

Disclosure of health information to families

298. As detailed in Chapter 27, Importance of families, partners, children, parents, siblings and wider family members are essential to the mental health and wellbeing of members. However, we heard about instances where family members were not told when their loved one was in crisis. One mother of a member who died by suicide said:

I'm his next of kin, I was his key emergency contact, I was the one he wrote to, I was the one he talked to, I was the one he would have reached out to, had he felt in a position to be able to reach out to me. He wasn't at that time. There needs to be much more inclusivity of family members.

... [H]ad I had a hint from Defence that he was struggling in the way he was struggling, I would have been on the next flight up there and taken him home myself.²⁴⁰

299. Defence Families of Australia told us that the Privacy Act has been 'part hurdle' and 'part excuse' for the lack of engagement with families:

[T]here is a severe lack of engagement and communication to Defence families throughout the lifecycle of a veteran's career. There must be genuine, consistent effort from Defence and DVA to engage directly with families from recruitment to post-service. Previously, the Privacy Act 1988 has been part hurdle, part excuse for this lack of communication.²⁴¹

300. The Royal Commission also heard from the Australian Institute Family Studies researchers who described research findings on the value of including family members in the rehabilitation of injured members.²⁴² According to Dr Stewart Muir, a senior researcher at the institute, the research found that consent was often lacking for family to be contacted but 'often there was very little follow-up or attempts to encourage members to invite their family to attend rehabilitation, or to impress upon them the advantages of doing so'.²⁴³ This was identified as an area for intervention, to ultimately deliver better rehabilitation outcomes.²⁴⁴
301. As detailed in Chapter 23, Transition from military to civilian life, the time immediately before and after a member separates from the ADF has been identified as a period of heightened vulnerability to suicidality. However, we received evidence that Defence did not provide families with adequate health information when a loved one was discharged with psychiatric symptoms.²⁴⁵ One parent lamented that they were suddenly put in charge of their daughter's care but did not feel that they were provided with sufficient information to be able to do so effectively.²⁴⁶
302. We understand that Defence's position is that unless it is required by law (for example, by a subpoena), or a 'permitted general situation' exists, Defence will not disclose health information to families in the absence of consent.
303. As the Chief of Army, Lieutenant General Simon Stuart, told us:
- It has been my experience that access to relevant individual health data is rarely accessible to commanders and indeed even to the families of our people, without the express consent of the soldier. This makes it very difficult for commanders to understand an individual's circumstances, assess risk, and facilitate appropriate support requirements. In other words, it is very difficult for commanders to fulfil their accountabilities and obligations for the health and wellbeing of those for whom they are responsible. The lack of information also creates stress for families and inevitably results in sub-optimal health and wellbeing outcomes for the soldier.²⁴⁷
304. This highlights the importance of obtaining members' informed consent to disclosing their health information to family members under certain circumstances. In our view, the process of obtaining consent to share certain kinds of information with family members under certain circumstances needs to be person-centred, proactive, flexible and regularly sought, so the consent is 'current'.²⁴⁸
305. Recommendation 12 of our *Interim Report* was that by March 2023, the Australian Government should increase the number of opportunities for serving or ex-serving ADF members to provide or amend their consent to disclose information to family members

or nominated representatives.²⁴⁹ In response, the government conducted a 'baselining exercise' to review all current mechanisms across Defence and DVA for current and ex-serving members to provide or amend their consent to disclose personal information to family members or nominated representatives.²⁵⁰

306. We welcome the government's commitment that a:

pro-active approach to consent for access to information will be taken to identify future opportunities that will build on initial improvements beyond March 2023, including an annual reminder for all members to review and update consent as required.²⁵¹

307. This needs to remain an ongoing priority to ensure that members and veterans experiencing distress and mental ill health are appropriately supported.

Where consent is not provided

308. We also acknowledge that an individual may decline to provide consent for their information to be shared beyond what is required by law. In that situation the Chief of Army Lieutenant General Simon Stuart told us that the Army respects the individual's wishes:

While Army's commanders are focused on the welfare support for the people under their command, I recognise that challenges exist to fulfilling their responsibilities when consent is not provided by the soldier. Army commanders must work within privacy law governing health and personal information. The involvement of families in the welfare management of soldiers is routinely considered with this in mind. Where a soldier declines to consent to the provision of their health information to a Welfare Board or to their family, Army respects the soldier's wishes.²⁵²

309. However, an individual's health information may be provided to commanders or managers where the individual has not consented.

310. The Defence Health Manual states that:

Commanders and managers may need to seek clarification of the health status of Defence members under their command/supervision from time to time, to enable their appropriate management. In these instances, the Defence members' consent is not required if the disclosure is limited to:

- a. **advice about how the Defence member's health condition affects their work.** The use of information relating to a Defence member's employability and deploy ability is limited to that which is detailed in MILPERSMAN Part 3 Chapter 2.
- b. non-clinical information such as an acknowledgment that a Defence member has attended a health consultation.²⁵³

311. Again, in our view, greater clarity is needed as to when the threshold of ‘how the Defence member’s health condition affects their work’ is satisfied in relation to distress and symptoms of mental ill health, and who within the chain of command may be given access to the member’s health information.

Where a ‘permitted general situation’ exists

312. A member’s health information may be disclosed if there is a ‘permitted general situation’. This is where it is ‘unreasonable or impracticable to obtain the individual’s consent’ to the disclosure and Defence ‘reasonably believes’ that the ‘disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety’.²⁵⁴
313. The Australian Information Commissioner told us the ‘recipient of the information may be relevant to whether the exception applies in the particular circumstances’.²⁵⁵

It is unclear how ‘serious threat to the life, health or safety’ is determined

314. The *Defence Privacy Policy* uses the language of the Privacy Act, but, in our view, does not set out clearly when, in the context of Defence, disclosure is necessary to lessen or prevent a serious threat to the life, health or safety, or to whom the information can be disclosed.²⁵⁶
315. However, we heard about situations where members were distressed and experiencing mental ill health, but this was not disclosed to families. This included situations where a loved one had made a suicide attempt. As the family member of a Navy member who died by suicide told us in a submission:

It is self-evident that the Navy alone were incapable of remedying this situation. If they were capable, his death, and the death of others, would not have occurred. Family help may have made the difference in some cases. For unknown reasons, perhaps shame, he chose not to inform his family of the attempt himself.

Apparently, privacy considerations limited the ability of the Navy to inform us. This raises the question: ‘When is medical privacy more important than maximising the possibility of saving a human life or minimising the possibility of suicide?’ This is especially true, in the case such as this, where a known unsuccessful attempt preceded his death. You cannot rely on the victim to inform their family, as a serious act such as suicide involves an unstoppable desire to succeed and seeking help goes against this desire. [Redacted] death, has left a deep and continuing impact on his father, sister and other members of the family. The sense that we failed him in his time of need haunts us all.²⁵⁷

316. It is difficult to see how a person experiencing suicidality or who has made a suicide attempt could be considered as not ‘present[ing] a serious threat to life, health or safety’ – in this case, their own. It is also difficult to see how disclosing the health information of that person in order to facilitate care and support might not be considered ‘necessary to lessen or prevent that threat’.

317. In our view, Defence needs to clarify what the ‘permitted general situation’ might look like in the Defence context, particularly when a member is experiencing distress or mental ill health that puts them at risk of suicidality and suicide.
318. Our strong preference remains that Defence continues to work to ensure that members and veterans understand how the Privacy Act operates and that they consent to their health information being shared in the event that they are distressed or experiencing mental ill health. This is critical to ensure that those able to facilitate appropriate care and support are in a position to do so.

Recommendation 68: Strike the right balance between upholding confidentiality and disclosing information when a member is in distress

Defence should ensure that members and commanding officers understand how the *Privacy Act 1988* (Cth) operates and the importance of members’ consenting to their health information being shared with those able to facilitate appropriate care and support, in the event members are distressed or experiencing mental health challenges.

To this end, Defence should:

- (a) continue its proactive approach to consent and provide regular training on the Privacy Act
- (b) regularly evaluate members’ understanding of the importance of consent and how Defence will use their personal information
- (c) by the end of 2025 and regularly thereafter (no less frequently than every three years), review its privacy policy and amend it as appropriate to ensure that it is clear, particularly with respect to:
 - (i) what it means to provide consent, and why consent is important, particularly for ensuring that family members are equipped with relevant information to support a members’ mental health and wellbeing
 - (ii) how members’ health information is reasonably necessary for, or directly related to, the functions and activities of the Australian Defence Force (ADF), including what ‘suitability for service from a health perspective’ means
 - (iii) when a ‘general permitted situation’ (as defined in section 16A of the *Privacy Act 1988* (Cth)) exists in the context of the ADF, particularly when a member is experiencing distress or mental health challenges that puts them at risk of suicidality

- (iv) when members' mental health information will be disclosed to their commander or manager to facilitate their wellbeing; when, in the context of the ADF, disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety, and to whom the information can be disclosed.

If barriers remain following review and amendment of the Defence privacy policy, then consideration could be given to subsequent legislative change, as part of the process set out in Recommendation 74.

Endnotes

- 1 Exhibit 69-03.017, Hearing Block 10, Defence Annual Report 2021–22, DEF.1151.0005.0032 at 0044.
- 2 Exhibit NN-01.015, Defence Health Manual, Vol 2 Part 1 Chapter 4 – Clinical Governance Framework, DEF.1297.0001.0001 at .0001 [4.3].
- 3 Exhibit NN-01.015, Defence Health Manual, Vol 2 Part 1 Chapter 4 – Clinical Governance Framework, DEF.1297.0001.0001 at .0001 [4.4–4.5].
- 4 Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, 2017 (Exhibit NN-01.010, DVS.6666.0001.0822).
- 5 *Defence Regulation 2016* (Cth) s 49.
- 6 Exhibit S-01.053, Defence Health Manual, Vol 1 Part 4 Chapter 1 – Eligibility for Defence health care, DEF.1413.0001.0034 at 0035 [1.6].
- 7 Exhibit S-01.053, Defence Health Manual, Vol 1 Part 4 Chapter 1 – Eligibility for Defence health care, DEF.1413.0001.0034 at 0035 [1.9–1.10].
- 8 Exhibit F-05.003, Health Service Level Charter, CLM.1001.0001.0925 at 0926 [1].
- 9 Exhibit M-01.062, Defence Health Manual, Vol 1 Part 1 Chapter 1 – Health authority and responsibilities, DEF.1411.0001.0001 at 0005 [1.20–1.21].
- 10 Exhibit M-01.062, Defence Health Manual, Vol 1 Part 1 Chapter 1 – Health authority and responsibilities, DEF.1411.0001.0001 at 0005 [1.19].
- 11 Exhibit M-01.062, Defence Health Manual, Vol 1 Part 1 Chapter 1 – Health authority and responsibilities, DEF.1411.0001.0001 at 0005 [1.19].
- 12 Exhibit F-05.003, Health Service Level Charter, CLM.1001.0001.0925 at 0927 [6].
- 13 Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, p 30-2815 [12–14]; Exhibit 97.02.002, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-258, DEF.9999.0187.0001 at 0005.
- 14 Exhibit 97.02.002, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-258, DEF.9999.0187.0001 at 0003.
- 15 Exhibit 97.02.002, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-258, DEF.9999.0187.0001 at 0003.
- 16 Exhibit 97.02.002, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-258, DEF.9999.0187.0001 at 0009.
- 17 Exhibit 20-03.036, Hearing Block 3, Joint Health Command Annual Review 2014–15, DEF.1029.0001.0054 at DEF.1029.0001.0057.
- 18 Exhibit 30-03.033, Hearing Block 4, Contract for the Provision of ADF Health Services, DEF.1033.0001.0086.
- 19 Department of Defence, *The Strategic Reform Program: Making it Happen*, p 18 (DVS.6666.0001.7430 Exhibit NN-01.011).
- 20 Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, p 30-2825 [39–40].
- 21 Exhibit 30-03.015, Hearing Block 4, Department of Defence, Response to Notice to Give, NTG-DEF-020, DEF.9999.0007.0001 at 0020; Exhibit UU-01.010, Department of Defence, Response to Notice to Give, NTG-DEF-184, DEF.9999.0197.0001 at 0022–0023; Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, p 30-2817 [45–47]; Transcript, Sarah Sharkey, Hearing Block 12, 21 March 2024, p 97-9883 [4–10].
- 22 Exhibit 30-03.027, Hearing Block 4, Department of Defence, Response to Notice to Give, NTG-DEF-020, Attachment D – Workforce data, DEF.9999.0007.0007.
- 23 Exhibit 30-03.027, Hearing Block 4, Department of Defence, Response to Notice to Give, NTG-DEF-020, Attachment D – Workforce data, DEF.9999.0007.0007.
- 24 Transcript, Sarah Sharkey, Hearing Block 12, 21 March 2024, p 97-9883 [18–33].
- 25 Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, p 30-2826 [30–34].
- 26 Exhibit F-05.003, Health Service Level Charter, CLM.1001.0001.0925 at 0927.
- 27 Exhibit F-05.003, Health Service Level Charter, CLM.1001.0001.0925 at 0927 [9].
- 28 Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, pp 30-2826 [39]–30-2827 [3].
- 29 Exhibit S-01.055, Defence Health Manual, Vol 1 Part 4 Chapter 3 – Garrison health service delivery model, DEF.1413.0001.0042 at 0043 [3.6].
- 30 Transcript, Sarah Sharkey, Hearing Block 4, 13 April 2022, p 30-2817 [6–10].
- 31 Exhibit 93-01.001, Hearing Block 12, Bupa, Response to Notice to Give, NTG-BUP-001, BUP.0002.0001.0001 at 0001, 0002, 0010–0014.

- 32 Exhibit 30-03.018, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Central Australia, DEF.9999.0007.0083; Exhibit 30-03.019, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Central NSW, DEF.9999.0007.0162; Exhibit 30-03.020, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Northern NSW, DEF.9999.0007.0226; Exhibit 30-03.021, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit North Queensland, DEF.9999.0007.0269; Exhibit 30-03.022, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Southern NSW, DEF.9999.0007.0303; Exhibit 30-03.023, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Southern Queensland, DEF.9999.0007.0335; Exhibit 30-03.024, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Victoria and Tasmania, DEF.9999.0007.0378; Exhibit 30-03.025, Hearing Block 4, Garrison Health Support Arrangements Joint Health Unit Western Australia, DEF.9999.0007.0440.
- 33 Exhibit 30-03.017, Hearing Block 4, Department of Defence, Response to Notice to Give, Annex B to NTG-DEF-020, JHU Facility Profile, DEF.9999.0007.0082.
- 34 Exhibit 30-03.027, Hearing Block 4, Department of Defence, Response to Notice to Give, NTG-DEF-020, Attachment D – Workforce data, DEF.9999.0007.0007 see Exhibit UU-01.010, Department of Defence, Response to Notice to Give, NTG-DEF-184, DEF.9999.0197.0001 at 0021 [64].
- 35 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0016 [44].
- 36 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0016.
- 37 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0016.
- 38 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0004 [11].
- 39 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0018 [50].
- 40 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0018 [50].
- 41 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0017–0018 [47, 50].
- 42 Andrew Moss, Submission, ANON-Z1E7-QETF-Q, p [2–3].
- 43 Exhibit 62-062.001, Hearing Block 9, Psychology Officer Special Air Service Regiment, Witness Statement, DEF.9999.0081.0011 at 0027 [63].
- 44 Exhibit 61-06.003, Department of Defence, Response to Notice to Give, NTG-DEF-105, DEF.9999.0078.0001 at 0018 [49].
- 45 Exhibit F.05.001, Department of Defence, Response to Notice to Give, NTG-DEF-185, DEF.9999.0121.0001 at 0008 [10]; Exhibit S-01.054, Defence Health Manual, Vol 1 Part 4 Chapter 2 – Provision of health care, DEF.1413.0001.0038 at 0040 [2.12].
- 46 Exhibit 63-03.004, Hearing Block 9, Ian Young, Witness Statement, DEF.9999.0074.0314 at 0328 [36]; Exhibit F.05.001, Department of Defence, Response to Notice to Give, NTG-DEF-185, DEF.9999.0121.0001 at 0008 [12, 15].
- 47 Exhibit 63-03.004, Hearing Block 9, Ian Young, Witness Statement, DEF.9999.0074.0314 at 0332 [53].
- 48 Exhibit S-01.055, Defence Health Manual, Vol 1 Part 4 Chapter 2 – Garrison health service delivery model, DEF.1413.0001.0042 at 0043, 0049-0050.
- 49 Exhibit S-01.055, Defence Health Manual, Vol 1 Part 4 Chapter 2 – Garrison health service delivery model, DEF.1413.0001.0042 at 0043.
- 50 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0005.
- 51 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0002.
- 52 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0005.
- 53 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0002.
- 54 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0002.

- 55 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0002.
- 56 Exhibit 33-03.073, Hearing Block 5, ADF Rehabilitation Program Procedures Manual, CLM.1001.0001.0275 at 0297.
- 57 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0005.
- 58 Exhibit V-01.005, Department of Defence, Response to Notice to Give, NTG-DEF-149, DEF.9999.0120.0006 at 0003.
- 59 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0003.
- 60 Exhibit 33-03.073, Hearing Block 5, ADF Rehabilitation Program Procedures Manual, CLM.1001.0001.0275 at 0302.
- 61 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0009.
- 62 Exhibit F-05.001, Department of Defence, Response to Notice to Give, NTG-DEF-057, DEF.9999.0074.0001 at 0009.
- 63 Exhibit F-05.004, Department of Defence, Response to Notice to Give, NTG-DEF-057; DEF.9999.0074.0001 at 0008.
- 64 Exhibit 33-03.073, Hearing Block 5, ADF Rehabilitation Program Procedures Manual, CLM.1001.0001.0275 at 0304.
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- 253 Exhibit S-01.059, Defence Health Manual, Vol 2 Part 3 Chapter 1 – Collection, use and disclosure of health information by Defence health personnel, DEF.1413.0001.0081 at 0085 [1.25] (emphasis added).
- 254 *Privacy Act 1988* (Cth) s 16A item 1.
- 255 Transcript, Angelene Falk, Hearing Block 4, 11 April 2022, p 28-2663 [36–37].
- 256 Department of Defence, *Defence Privacy Policy*, November 2022, p 6 (Exhibit CC-01.019, DEF.1197.0004.0346).
- 257 Gary Golding, Submission, ANON-Z1E7-Q8PS-K, p [2].

17 ADF and DVA suicide prevention programs and initiatives

Summary

The Australian Defence Force (ADF) has had a Suicide Prevention Program in place since 2002. Despite this, rates of suicide and suicidality among serving and ex-serving members have not declined.

The Department of Veterans' Affairs (DVA) also has several suicide prevention programs and initiatives, though some of these have been temporary pilot programs and subject to funding constraints.

In this chapter, we describe the ADF Suicide Prevention Program, including its awareness-raising initiatives, training and clinical services, and identify areas for program improvements.

We set out ways to enhance mandatory suicide prevention awareness and skills training to make it more meaningful and effective. Lived experience and expert professional witnesses told us that some members regard this training as 'tick and flick', rather than it being given the attention it deserves. Commanding officers and instructors also need additional mandatory training tailored to their unique role in supporting the health and wellbeing of those under their command.

We discuss the challenges with suicide risk assessments and with accessing appropriate crisis care. We also report on the findings of an ADF audit that identified the ADF's own standards for the management of acute and crisis situations were not always followed.

In this chapter, we also recognise the important role that high-quality aftercare support has in reducing future risk of suicide and suicidality. We suggest that the ADF's approach to aftercare currently lacks focus on recovery and reintegration into work.

Finally, the chapter describes the DVA's suicide prevention programs and initiatives, and its approach to identifying and supporting clients at risk. We observe that in the absence of a specific suicide prevention strategy, the activities appear to be uncoordinated and lacking direction.

In response to these issues, we make recommendations that aim to:

- enhance ADF suicide prevention training and make it more engaging by drawing on lived experience and offering face-to-face delivery, and by tailoring training to support the special role that leaders have in supporting members' health and wellbeing
- improve ADF clinical protocols for managing members experiencing a mental health or suicidal crisis, and for providing quality aftercare to better facilitate recovery and support the member in returning to their work in a safe, person-centred manner.

17.1 Introduction

1. The Royal Commission has consistently been told that preventing suicides among ADF members and veterans is a priority.
2. In 2024, during our final hearing, then Chief of the Australian Defence Force, General Angus Campbell AO DSC, told us suicide prevention is ‘the highest of our [personnel wellbeing] priorities’.¹
3. In 2022, he told the Royal Commission that:

I think [suicide] is an extremely complex challenge, problem, and there is a great deal of effort going on but more is needed. We ... have to keep working at it. And so, where issues of culture are at play, these things can take a number of years and I realise, Counsel, that we don’t have a number of years. It is a very, very serious issue and these are our people and the numbers ... are very, very concerning.²
4. Similarly, in 2023, Counsel Assisting asked the Secretary of DVA, Ms Alison Frame, ‘to what extent have wellbeing and suicide prevention been discretely and explicitly raised as priorities requiring [the Department of Veterans’ Affairs’ (DVA’s)] attention?’³ She replied that ‘[wellbeing and suicide prevention] pervades all of the thinking in the department’ and while she explained that DVA is only ‘part of the system and part of a service response’, she confirmed ‘[DVA has] a key role there and ... that’s been prominent in all of the considerations about how can the department do that better’.⁴
5. Despite these acknowledgements, suicide rates within the Australian Defence Force (ADF) member and veteran cohorts have not declined.
6. Also, despite stating that suicide prevention is a priority, it is not always clearly articulated as such by Defence, and DVA.
7. In Hearing Block 12, Commissioner Peggy Brown asked Defence Secretary Mr Greg Moriarty AO about the extent suicide prevention was a priority. Commissioner Brown said it is ‘not immediately apparent – if you go and look at any of the documents, even the portfolio budget statements, the corporate plan – that suicide prevention is as important as nuclear submarines to the Department of Defence’.⁵ To which the Secretary responded ‘... I think that we do need to call it out more particularly’.⁶
8. And, as we explain in section 17.3.1, DVA does not have an explicit suicide prevention strategy outlining its relevant commitments. Instead, suicide prevention actions have been incorporated into a broader mental health and wellbeing strategy.
9. Defence and DVA are developing a specific suicide prevention action plan.⁷ It will sit under the new joint *Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029*, which at the time of writing was being drafted. Further information on the new joint strategy can be found in Chapter 15, Promoting health and wellbeing among ADF members.

10. As discussed in Chapter 1, Understanding suicide, the problem of suicide and suicidality is complex, and there is no 'one size fits all' solution. Instead, suicide prevention measures need to be comprehensive and multidisciplinary.
11. Former National Mental Health Commissioner Mr Alan Woodward told us:

[T]he starting point to a whole-of-government approach [to suicide prevention] is to recognise that suicide is a multifactorial, complicated behaviour. So, as we've discussed, it may be different for individuals. What drives those suicidal urges and suicidal behaviour might be health-related, might be mental health-related, might also be housing-related or financial matters related or family and relationship matters. So, therefore, the importance of being alert to a person in distress, whatever the nature of the service is, is part of whole-of-government approach.⁸
12. Despite its complexity, suicide can be prevented. Concerted and long-term effort is required, and it should come from all levels of government and across all portfolios. The community also plays an important role. Everybody has a responsibility.

17.1.1 Suicide prevention in the Australian context

13. In growing recognition of the problem, and the need for a coordinated approach, suicide prevention has been stated as a national priority since at least 2019.⁹ In this section, we briefly describe the key national suicide prevention policy and strategies.

The National Suicide Prevention Adviser

14. In 2019, then Prime Minister the Hon Scott Morrison MP appointed Australia's first National Suicide Prevention Adviser, Ms Christine Morgan. The appointment was to bolster efforts 'towards zero suicides' in Australia.¹⁰
15. Ms Morgan's role was to provide advice on:
 - (a) reducing the risk of the kind of distress that leads to suicide and self-harm
 - (b) making sure people who find themselves in distress get immediate and effective support
 - (c) finding ways to connect services and empower all of us to recognise and respond to people in distress and instil hope.¹¹
16. Interim Advice was provided to the government in August 2020 and Final Advice in December 2020.¹²
17. The Final Advice consisted of three complementary reports that included eight recommendations as well as required 'priority shifts' and 'key enablers' to strengthen suicide prevention.¹³ These are summarised in Box 17.1.

Box 17.1 National Suicide Prevention Adviser's Final Advice

The Final Advice recommends that all governments:

- (1) work together to deliver a whole-of-government approach, with national outcomes to be developed and adopted by all governments
- (2) commit to integrate lived experience knowledge into national priority setting, planning, design, delivery and evaluation of suicide prevention services
- (3) commit to work together to identify data needed for such measurement, undertake to improve the quality and timeliness of that data, and enable sharing across agencies
- (4) commit to prioritising evidence-based and compassion-focused workforce development to drive cultural change in, and improve the capacity and capability of, all workforces involved in suicide prevention
- (5) work together to develop and implement responses that provide outreach and support at the point of distress, to reduce the onset of suicidal behaviour
- (6) work together to progress service reform for integrated, connected and quality services for people experiencing suicidal distress, people who have attempted suicide as well as caregivers and people impacted by suicidal behaviour.
- (7) apply an equity approach to suicide prevention planning and funding to target populations that are disproportionately impacted by suicide
- (8) build capabilities within key policy teams and departments and review existing policies to enhance opportunities for improved security and enhanced safety through a national strategy.

Key enablers:

- leadership and governance to drive a whole-of-government approach
- lived experience knowledge and insight
- data and evidence to drive outcomes
- workforce and community capability.

Key shifts:

- responding earlier to distress
- connecting people to compassionate services and supports
- targeting groups disproportionately affected by suicide
- delivering policy responses that improve security and safety.

Establishment of the National Suicide Prevention Office

18. The National Suicide Prevention Office (NSPO) was established in May 2021 in response to the National Suicide Prevention Adviser's Final Advice and recommendations from the Productivity Commission's inquiry into mental health.¹⁴
19. The NSPO currently sits within the National Mental Health Commission. However, as of 1 October 2024, the functions of the National Mental Health Commission, including the NSPO, will be transferred into the Department of Health and Aged Care.¹⁵
20. It is unclear to us if this move will change the role of the NSPO, which is to:
 - coordinate a whole-of-government approach to suicidality
 - develop the National Suicide Prevention Strategy
 - lead and develop a suicide prevention national outcomes framework. This is to be applied 'nationally and down to program and service level'
 - set priorities for suicide prevention, and organise research, data, knowledge and information sharing across jurisdictions
 - lead work across jurisdictions to develop a National Suicide Prevention Workforce Strategy.¹⁶
21. The NSPO undertakes its role by working 'across governments, portfolios and sectors to drive the development of a nationally consistent and integrated approach to suicide prevention'.¹⁷ It supports all levels of government to commit to and invest in coordinated action to reduce instances of suicide. It also acts as a watchdog, monitoring and reporting 'on national outcomes'.¹⁸
22. The NSPO established the first national suicide and self-harm monitoring system. The system maps suicide and self-harm data across the country and works to strengthen prevention strategies and understanding of suicidal behaviour.¹⁹

Development of the National Suicide Prevention Strategy

23. The NSPO is responsible for developing the National Suicide Prevention Strategy. Development began in 2022 and at the time of writing was ongoing.²⁰
24. The intent of this strategy is to:

guide coordinated action across all governments, government agencies and organisations, and communities in order to achieve an Australia in which no person feels driven to take their own life ... The Strategy will aim to create a national shared understanding of the changes needed and outline the actions required to achieve suicide prevention reform, setting a long-term direction as well as identifying priority areas for improvements and resource allocation over the next 5 years.²¹

25. It is intended to realise the goals and direction outlined in the National Suicide Prevention Advisor's Final Advice.²² This includes the identification of veterans as a priority cohort that would benefit from targeted interventions.
26. This strategy will also build on the *National suicide prevention strategy for Australia's health system: 2020–2023*, which, as the title suggests, is focused specifically on the health system.²³

National Mental Health and Suicide Prevention Agreement

27. Signed in March 2022, the National Mental Health and Suicide Prevention Agreement sets out the shared intention of all governments to work together to improve the mental health of all Australians and reduce the rate of suicide.²⁴
28. The agreement identifies ADF members and veterans as one of the priority population groups.²⁵ It also designates that the Commonwealth will be 'primarily responsible' for 'funding and provision of mental health and suicide prevention services to veterans, defence force personnel ...'²⁶

17.1.2 The right supports at the right time, informed by evidence

29. Suicide prevention includes both the prevention of deaths by suicide and the prevention of suicidal behaviours, such as attempted suicide and suicidal thoughts.²⁷
30. Preventative approaches include a spectrum of activities that target:
 - preventing the onset of suicidal behaviour
 - intervening early and effectively to reduce suicidal behaviour
 - lowering the impact of suicide.²⁸
31. Prevention activities are also sometimes classified as universal, selected and indicated. As Professor Jane Pirkis, Director of Melbourne University's Centre for Mental Health, told us:

[T]he difference between universal, selective and indicated interventions is about who they are exclusively targeting. Universal interventions target the whole population; selective interventions target people who are at risk but not yet making a suicide attempt or thinking about suicide; indicated interventions target people who are actively thinking about suicide or have made a suicide attempt ... I mean, it's quite epidemiologically driven, I guess, because it is about risk factors, really, in the end. Other people working in suicide prevention might think about things a bit differently, depending on where they are coming from. Clinical folk, most of whom work in the indicated intervention area, might think about the clinical services they offer in different ways and some of them are teetering into treatment

services. So, they're not just prevention, they're sort of on the edge between prevention and treatment. But this taxonomy – universal, selective and indicated – is very commonly used.²⁹

32. Examples of universal suicide prevention interventions include:

- community education about suicide to build community awareness³⁰
- means restriction (reducing the availability and attractiveness of the means of suicide)³¹
- strategies to confront stigma that would discourage help seeking³²
- building and supporting a competent, compassionate workforce (able to respond to suicidal threat)³³
- developing a thriving culture and healthy workplace³⁴
- building resilience through helping serving and ex-serving members to manage their mental health and wellbeing using technology and personal support networks.³⁵

33. Examples of selective suicide prevention interventions include:

- training and education programs about suicide for health professionals, identified gatekeepers and families³⁶
- effective treatment services that are evidence based³⁷
- crisis response services, including, for example, crisis hubs for members, former serving members and their families³⁸
- developing a specific/tailored strategy for First Nations communities, LGBTQI+ communities and other at-risk populations³⁹
- adopting a model of 'person-centred care' (helping the individual connect with the most appropriate services).⁴⁰

34. Examples of indicated suicide prevention interventions include:

- continued contact with treatment and support services post crisis and the extension of aftercare services to anyone experiencing suicidal distress (behaviour and ideation)⁴¹
- improved postvention response to and caring for family and friends affected by suicide.⁴²

35. As Professor Pirkis further noted, a robust approach to suicide prevention ideally includes measures targeted at each level and designed to interact with one another in a cohesive, systemic way:

[B]ecause we're still learning what works and what doesn't work in suicide prevention, it's worth trying a range of different things in a fairly considered way, and it's also worth putting in place universal, selective and indicated interventions together so that they are good synergies, and I guess that the whole is greater than sum of the parts ... So, kind of a full suite of different interventions delivered in a coordinated systemic way in a particular area at the same time.⁴³

36. Suicide prevention measures should also be informed by best practice. Experts on best practice in suicide prevention, and on suicide prevention program development and evaluation, should be regularly engaged by Defence.

37. The measures should also be informed, where possible, by the lived experience of suicide and suicidality. As Professor Pirkis told the Royal Commission:

I think that there is stuff that can be learnt from the broader suicide prevention field and the programs and interventions that seem to be useful, and thinking through how they might be applied in [the ADF] context, but also I would say, the last thing I said, that in doing that, it would be really important to make sure that they're shaped by current and former serving members, with and without lived experience of suicide, and their families.⁴⁴

38. In 2020, Suicide Prevention Australia partnered with people who have lived experience of suicide, clinicians, service providers and accreditation experts to develop the *Suicide Prevention Standards for Quality Improvement*. Informed by best practice, these standards were updated in 2022 and govern Suicide Prevention Australia's Suicide Prevention Accreditation Program.⁴⁵

39. These standards provide a useful lens for considering whether the ADF Suicide Prevention Program achieves best practice. They are:⁴⁶

- Alignment

Clear 'line of sight' between the program's aims and objectives and those of the broader organisation (or partnership).

- Lived and living experience of suicide

The voice of people with lived and living experience of suicide informs all aspects of the program.

- Collaboration

Actively seeking and building relationships, partnerships and collaborations, both formally and informally.

- Program framework

The behind-the-scenes functions that wrap around the program when it is being delivered.

- Program management
How the program is designed and implemented to ensure a safe and supportive environment for all who interact with it.
- Program outcomes and knowledge sharing
How the program collects, analyses and learns from feedback, implementing those learnings to improve the program and inform the wider suicide prevention sector.⁴⁷

40. As this chapter argues, the ADF suicide prevention program and DVA suicide prevention programs and initiatives do not always rise to these standards.

17.1.3 The scope of this chapter

41. The purpose of this chapter is to describe and analyse the ADF Suicide Prevention Program as well as DVA's programs and initiatives specifically targeting suicide prevention. We note that postvention is discussed separately in Chapter 20.
42. Other programs and services that are not specifically targeted at suicide prevention, but are nonetheless related, are discussed in other chapters of this report. Specifically:
- ADF mental health promotion and awareness-raising initiatives, as well as preventative health and early intervention initiatives are discussed in detail in Chapter 15.
 - ADF health and mental health care services are discussed in Chapter 16.
 - Health care for ex-serving members is discussed in Chapter 18.
 - Open Arms is discussed in Chapter 19.
 - Wellbeing supports for ex-serving members is discussed at Chapter 24, Empowering veterans to thrive.

17.2 The ADF Suicide Prevention Program

43. The ADF set up its Suicide Prevention Program (SPP) in 2002.⁴⁸ According to Defence, the SPP aligns with the National Suicide Prevention Advisor's Final Advice, and the recommendations of the 2020 Productivity Commission Review into Mental Health.⁴⁹
44. The SPP has five goals:
- prevent premature deaths
 - reduce incidence of suicidal behaviour
 - determine risk factors unique to ADF
 - minimise after-effects and trauma on family and community
 - promote resilience, problem solving, wellness, cohesion and support.⁵⁰

45. The program's activities can be grouped into three key action areas:⁵¹
- suicide prevention awareness raising and skills training
 - clinical services, including risk assessment, safety planning and treatment
 - surveillance, including suicide and self-harm monitoring and reporting.
46. Our detailed analysis of Defence suicide surveillance, including data collection, monitoring and reporting is included in Chapter 29, Use of data and research by Defence and DVA. The other two action areas are discussed below.

17.2.1 Suicide prevention awareness raising and skills training

47. Defence takes a stepped approach to its suicide prevention awareness raising and skills training action area:
- Step 1 – Suicide prevention awareness
 - Mandatory annual awareness training – 'Defence Suicide Awareness' is a one-hour annual awareness presentation that can be presented by Defence mental health personnel, medical officers or chaplains, or accessed via the Defence online learning system (CAMPUS). It is mandatory for all ADF members to complete awareness training annually.⁵²
 - In 2024, the training was updated to support the introduction of the SafeSide Framework in Defence.⁵³ SafeSide is an evidence-based, recovery-oriented suicide prevention program that includes workforce education, policies and practices.⁵⁴
 - Step 2 – Suicide prevention alertness
 - A series of three workshops that build on the annual Suicide Prevention Awareness training and aim to develop mental health literacy and suicide prevention skills.
 - The workshops are targeted at peers, junior leaders and commanders or managers, and they are delivered face to face.
 - The three workshops are:
 - Keep Your Mates Safe – Suicide Prevention
 - Keep Your Mates Safe – Mental Health Awareness
 - Keep Your Mates Safe – Mental Health First Aid.⁵⁵

- Step 3 – Suicide prevention skills training
 - A two-day workshop delivering the LivingWorks Applied Suicide Intervention Skills Training (ASIST) program targeted at junior leaders, commanders, managers, chaplains, health providers, member support coordinators, unit welfare officers, equity and diversity officers.⁵⁶
 - The training provides participants with the skills to identify at-risk individuals and provide initial mental health support.⁵⁷
 - Step 4 – Mental Health Risk Assessment Training for mental health professionals
 - This was developed by Phoenix Australia for Defence mental health professionals and medical officers and is focused on developing skills for assessment and management of members at risk of suicide or self-harm.⁵⁸
48. Defence has confirmed via responses to our notices that the four steps of suicide prevention training have been developed to be consistent with best practice evidence for suicide prevention and awareness raising.⁵⁹
49. Notwithstanding this, we have identified opportunities for improvement, which are detailed next.

Effectiveness of the SPP is unknown as it has not been adequately evaluated

50. The ADF Suicide Prevention Program has been subject to several reviews, but its effectiveness at improving mental health outcomes has not been evaluated due to limitations with Defence's data collection and surveillance systems. We also note that the recommendations identified from previous reviews have not always been implemented, or are still under consideration years later. This suggests to us that Defence is not prioritising suicide prevention efforts.
51. The SPP was first reviewed by the Australian Institute for Suicide Research and Prevention (AISRAP) in 2011–12. The purpose of the AISRAP's review was to evaluate the SPP's 'best practice compliance, in accordance with the needs of military and to identify gaps'. The AISRAP concluded that the ADF SPP 'includes most of the important components of the current best practice of an effective SPP' and 'compared favourably to those of [Australia's] allies and included the key features of the military SPPs of the US and Canada'.⁶⁰
52. It nevertheless identified several gaps, including the lack of a well-organised follow-up system and the limited surveillance system or suicide registration database. As a result, the AISRAP made 10 recommendations to improve the SPP. Defence considers eight of those recommendations – which included ensuring better targeted and culturally-relevant training and education, ensuring adherence to best practice principles, and 'paying attention' to continuity of care – to have been implemented in full.⁶¹ We understand that implementation of the remaining two recommendations are ongoing. Those recommendations were that Defence should '[i]mprove the surveillance system to track suicides' and:

continue to develop and evaluate other mental health programs, such as BattleSMART and the Alcohol, Tobacco and Other Drug Program, which support the reduction of suicide risk factors and help to prevent suicides.⁶²

53. The SPP was next reviewed by Phoenix Australia as part of its development of the Continuous Improvement Framework (CIF) in 2015. The CIF is Defence's framework for continuously improving the quality and effectiveness of mental health and wellbeing programs and services, including the SPP.⁶³
54. The 2015 Phoenix review emphasised the need for expert input into development of materials, pre-program testing and validation, standardisation and consistency in implementation, post-program evaluation, monitoring and reporting, and systems to support the initiative.⁶⁴
55. Phoenix summarised its feedback (on each of the SPP steps) as follows:
 - Step 1:

There is room to improve oversight of the content delivery. The program is unlikely to produce large changes in awareness, but potentially will have a cumulative impact over time leading to gradual movement toward the strategic objective.⁶⁵
 - Step 2:

Delivery is generally reactive. Bedding down and implementing the standardised KYMS [Keep Your Mates Safe] questionnaires data collection and data management processes is a short-term priority.⁶⁶
 - Step 3:

The ASIST course is well accepted and internationally consistent with other militaries, and evidenced-based (to a point) ... Consideration needs to be given to whether the training and credentialing requirements are a barrier to professional upskilling. Whether people trained in [ASIST] use the approach should be examined as part of the evaluation.⁶⁷
 - Step 4:

[T]raining is currently being revised. The new course will have data collection incorporated ...⁶⁸
56. In 2019, in the second phase of the CIF's development, Defence approved the CIF Monitoring and Evaluation System.⁶⁹ The University of Canberra is overseeing the system's implementation, having started in 2020.⁷⁰
57. The University of Canberra project was originally supposed to evaluate the effectiveness of the *Defence Mental Health and Wellbeing Strategy 2018–2023*, the SPP, and various mental health promotion programs and initiatives.

58. However, the university's interim report, which was delivered in March 2021, found that the ADF's data collection and analysis processes, as well as the type of data it collected, were such that the researchers were unable to accurately measure mental health outcomes or evaluate the strategy or individual programs.⁷¹

59. The researchers wrote:

As an example of the insights offered by our preliminary exploration, various stakeholders expressed a belief that systems such as [Defence electronic health system] contain substantial 'data' that would answer almost any [Suicide Prevention Program monitoring and evaluation] questions. Upon initial exploration of how such information is recorded – primarily for record keeping and compliance purposes – and also the practical realities of how such data could be accessed and analysed, we would urge caution regarding such beliefs.⁷²

60. They continued:

Even if data is consistent in entry and quality, it does not mean that it is suitable for use to assess mental health outcomes. For instance, attendance at a suicide prevention training event may correlate with greater awareness of mental health as an issue, but it does not necessarily result in increased literacy and knowledge, or reduced stigma around suicide behaviours.⁷³

61. Indeed, the researchers noted that while data on program delivery and engagement (for example, attendance at training or completion of online training courses) was routinely collected, such activities 'do not automatically or directly translate to mental health outcomes'. They further noted that it was 'unclear' whether the activities in question 'generate a measurable reduction in stigma around suicide'.⁷⁴

62. The University of Canberra researchers made 26 recommendations to improve data collection, which were endorsed for implementation by Defence on 30 July 2021. However, as of March 2022, Defence still had not actioned any of these. Instead, it told the Royal Commission that implementation was 'in the design and planning stage'.⁷⁵ A year later, in July 2023, Defence told the Royal Commission that the Draft Implementation Plan was 'still considered to be a draft as it has not been formally signed off yet' but that 'Defence is progressing with implementation of the recommendations'.⁷⁶

63. In late 2021, it was agreed that:

[a] full [CIF monitoring and evaluation] project rescoping was required because the original assumptions underpinning the agreed program of work no longer held, and previously identified data was not fit-for-purpose, meaning the [original CIF monitoring and evaluation] brief was not implementable.⁷⁷

64. In December 2023, the University of Canberra provided an update on their preliminary findings concerning the rescoped evaluation of the *Defence Mental Health and Wellbeing Strategy 2018–2023* and CIF.⁷⁸

65. It is concerning to us is that in relation to the SPP objective – ‘Build the capacity and capability of the mental health workforce to support individuals at risk of suicide’ – the University of Canberra again found that:

There was no relevant data available for this evaluation and we have no way to determine the quality, accessibility, appropriateness or responsiveness of these services.⁷⁹

66. We acknowledge that measuring outcomes can be difficult. However, throughout our inquiry we have identified numerous examples where relevant outcomes and indicators are not identified, and evaluation is either poorly conducted or not conducted at all. We do not think this is good enough given the critical nature of the problem.
67. These examples are documented throughout our report, and the issue is dealt with in detail in Chapter 29, Use of data and research by Defence and DVA. In that chapter, we recommend Defence and DVA create evaluation and research teams in a central area of their respective departments to improve the coherence of defence and veteran health and wellbeing research and evaluation practices, see Recommendation 116. The Suicide Prevention Program must be prioritised for further evaluation.

Is mandatory awareness training ‘tick and flick’?

68. As described above, the SPP includes a range of training programs delivered via different formats. In this section, we specifically focus on the first step of the SPP training, which is the only training that is mandatory for all members across the enterprise.
69. The first step of the SPP training is regularly delivered as an e-learning module. Submissions and lived experience accounts suggest that some members do not take these programs seriously, regarding them in many instances as mere ‘tick-and-flick’ exercises.⁸⁰ For example:

Look, there’s mental health education provided by Navy and Defence currently. Again, it stinks of a tick-and-flick-type exercise when you say that it’s an annual course that you have to do. Myself and everyone I know that’s ever attempted or conducted that course is just a ‘Click through it and get it done’ because it’s an admin burden that is actually providing me with no education.⁸¹

70. Asked what a more effective form of awareness training would look like, former Navy diver Ashley Semmens told the Royal Commission, ‘I guess the gold-plated suggestion would be someone there with the lived experience supported [by] or supporting a mental health professional’.⁸²
71. The National Mental Health Commission has previously made recommendations along these lines. In its 2017 *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*, the National Mental Health Commission recommended that:

The ADF mandatory training on mental health awareness and suicide prevention should be reviewed and strengthened via a co-design process, with the aim of developing training that appropriately contextualises the occurrence of mental illness and educates service personnel on risk and protective factors, the concept of recovery and the benefits of early intervention. Consideration could also be given to training being delivered by peer workers with lived experience of military service and mental health issues or suicidality, possibly in association with an ESO.⁸³

72. In response to this, Defence agreed to ‘complete a review of current mandatory training to consider methods of increased engagement and strengthening of the training’. It did not specifically mention using a co-design process nor anything about peer delivery.⁸⁴ Defence has told us that it had finished implementing the recommendation on 30 December 2018.⁸⁵ By way of explanation, Defence pointed to the CIF, referred to earlier in this section. We do not agree that implementation of the CIF to date achieves the intent of the National Mental Health Commission recommendation.
73. We strongly believe that training on mental health awareness and suicide prevention would benefit from being co-designed by serving and ex-serving members with lived experience. Pleasingly, it seems Defence agrees. In 2024, the mandatory suicide prevention awareness training was updated to include lived experience perspectives.⁸⁶
74. We also believe that the training would benefit from being co-delivered by peers with lived experience of mental health issues or suicidality.
75. A peer-delivered program would bring the ADF into alignment with several other suicide prevention initiatives, such as MATES in Construction. That program generally consists of a one-hour General Awareness Training session, which is delivered on-site and in-person to at least 80% of the workforce at the same time. It seeks to:
- raise workers’ awareness and understanding of mental ill-health and suicide in the workplace
 - develop site-based peer intervention capability to identify and connect vulnerable workers to appropriate support
 - ensure workers’ easy access to practical, professional and appropriate support.⁸⁷
76. It further consists of ‘connector training’, which trains volunteer workers as ‘gatekeepers’ who can identify warning signs of suicidality and respond to those at risk. The ASIST (Applied Suicide Intervention Skills Training) component, which comprises the third stage of the SPP, is also made available to certain ‘key workers’.⁸⁸
77. Professor Pirkis told the Royal Commission that a model like MATES might prove helpful in the ADF:

In terms of selective interventions, I was thinking that there are models elsewhere that might be helpful [and] I was thinking about the model of MATES in Construction, which has now expanded to other industries ... [I]t’s selective

[prevention] in the sense that it might not be people who are actively thinking about suicide who would be the beneficiaries of it, but it would be people who were just not chugging along quite as well as they normally might.⁸⁹

78. There have been evaluations and assessments of MATES in Construction in Australia and New Zealand. A 2021 longitudinal assessment of the model in New Zealand found that participation in the program resulted in ‘significant improvements on the participants’ suicide awareness, confidence and competence to support co-workers in distress and to connect them to appropriate support’. A 2020 longitudinal assessment of MATES in Construction in Australia produced similar results.⁹⁰
79. Expert witnesses to the Royal Commission spoke of the effectiveness of group-based suicide prevention programs, often with an emphasis on peer delivery. For example, Dr Anthony Pisani of the SafeSide Prevention consultancy and training organisation spoke of the Wingman Connect program developed by Dr Peter Wyman at the University of Rochester. The program involves group training followed by text and video follow-ups. A randomised control trial showed that US Air Force trainees who received such training had reduced suicide risk and depressive symptoms in the short term across one month, with a number of those effects persisting, particularly regarding depression, once they had entered the operational space.⁹¹
80. Dr Pisani said, ‘We call this network-informed suicide prevention, where we are intentionally focusing on not just each individual but the properties of the group.’⁹² He continued:

[W]ith youth and young adults especially, really with all of us, but especially for that, we make changes in relation to the people around us. The norms of a group really matter, and the voice of somebody like us is really powerful.⁹³

81. While we note there have been recent updates to the annual suicide prevention awareness training, we see a need for further enhancements, including through the use of face-to-face delivery and involvement of members with lived experience.

Additional mandatory training for leaders and instructors

82. In our view, Defence needs to provide commanders and training instructors with additional mandatory suicide prevention training, tailored to their unique needs. They are often gatekeepers to mental health support and have a strong influence on organisational culture and help-seeking behaviours.
83. As we discuss in more detail in Chapter 7, Culture and leadership, we are concerned that ADF leaders do not have what they need to support their teams to thrive. In 2023, discussions between the Centre for Defence Leadership and Ethics and the Director General Mental Health and Wellbeing revealed that:

Defence’s leaders are not yet fully supported with the policies, procedures, resources, and training required to support their people to thrive, provide direct initial care of their people facing challenges, and subsequently refer their people to support pathways.⁹⁴

84. Based on Defence's response to our notice to give information, other than the mandatory annual awareness training for all staff, we understand that there is no single other mandatory suicide prevention training for commanders and instructors, across the three services.⁹⁵ Although, we note that leaders and instructors have access to a range of resources, including a 'Leaders toolkit', which provides advice on how to support members mental health and wellbeing during challenging times.⁹⁶
85. We think additional training for commanders and instructors should describe risk factors and how commanders and training instructors can identify and reduce them, as well as how to intervene early and support those under their command. For example, as we discussed in Chapter 14, Introduction to health care for members and veterans, sleep problems are a risk factor for suicide and suicidality. Fatigue management is within the control of commanding officers and its importance should not be understated. Training should emphasise the link between inadequate sleep and suicide risk, and provide practical strategies to support commanding officers in managing this risk.
86. One option that could be considered is making the third step of SPP – Applied Suicide Intervention Skills Training (ASIST) – mandatory for anyone undertaking a command position or recruit school instructor role.
87. ASIST is a widely used and accepted suicide intervention skills training package developed by the Canadian public service corporation LivingWorks. It consists of a two-day workshop that aims to enhance caregiver intervention skills until either the immediate risk of suicide is reduced or additional life-assistance resources can be found.⁹⁷ It is considered best practice and is delivered in other militaries (such as in the US, Canada and Norway).⁹⁸
88. A 2013 study found that callers to the US National Suicide Prevention Lifeline's national network of crisis hotlines were significantly more likely to feel less depressed, less suicidal, less overwhelmed and more hopeful by the end of calls handled by ASIST-trained counsellors.⁹⁹ In addition, US Army personnel and associated civilians reported significantly greater confidence, preparedness and likelihood to intervene after ASIST training.¹⁰⁰
89. This Royal Commission is not the first to suggest that ASIST be made mandatory for people assuming command positions. When the SPP was reviewed by the Australian Institute for Suicide Research and Prevention in 2011–12, one of its recommendations was that the ADF should 'ensure better-targeted and culturally-relevant training and education in order to improve mental health and suicide awareness in the ADF'. It singled out ASIST for praise and urged that its provision continue.¹⁰¹
90. The Australian Institute for Suicide Research and Prevention noted that 'there is the need for more training and education of commanders and higher ranks ... on the different options available to them for dealing with members in distress'.¹⁰² The Institute's focus group participants told it that:

[ASIST] training needs to be more accessible and more ASIST courses need to be run to reach a wider proportion of the workforce. Furthermore, the need for more training and education of commanders and higher ranks was acknowledged. One option is to make ASIST a prerequisite for promotion, as recommended by some members.¹⁰³

91. In Chapters 14 and 15, we discuss the important role that commanders have in supporting the health and wellbeing of those members under their command, as well as their gatekeeper role. We therefore think it is vital that commanders receive tailored training to better meet their duty of care to the members under their command. Similarly, such training would be of benefit to all ADF members in leadership positions, including recruit school instructors.

Recommendation 69: Improve suicide-prevention training so it is practical, tailored, informed by lived experience and delivered in person

The Australian Defence Force should revise and improve its suicide-prevention training so it:

- (a) focuses on practical rather than theory-based learning, and ensures members are familiar with what support is available
- (b) is scaled, to emphasise different levels of responsibility, from junior ranks to commanders. Specific training should be offered to senior leaders, which sets out how they can support those under their command
- (c) is informed by, and involves, members with lived experience of suicide, suicidality or mental health
- (d) delivers all suicide prevention training in-person by no later than 31 December 2025.

17.2.2 Supporting at-risk or suicidal members

92. In section 17.2.1 we discuss suicide prevention awareness-raising and skills-training initiatives offered by ADF. These are largely an example of ‘universal’ interventions, but with some ‘selective’ interventions – for example, targeted training for gatekeepers and health workers.
93. In this section we move on to discuss suicide prevention clinical services offered to ADF members. Such interventions are considered ‘selective’ or ‘indicated’ as they are offered to members who are at risk of making a suicide attempt, or who may be experiencing suicidal crisis.

94. Suicidality can often precede death by suicide, making it an important opportunity for proactive suicide prevention and the delivery of targeted and caring support.¹⁰⁴
95. Unfortunately, it appears that not enough is being done to adequately support members experiencing suicidality. Research that we commissioned estimated that one serving or ex-serving member has a suicide-related contact with emergency services (police and/or paramedics) every four hours across Australia.¹⁰⁵ This suggests a need to identify risks and intervene earlier to facilitate support. As well, appropriate crisis care facilities must be available.
96. All defence personnel have a role in identifying members at risk and facilitating support. This includes:
- a. identifying and managing potential risk to themselves or others
 - b. reporting comments and behaviours that may be indicative of risk to the commander, manager or Defence health personnel
 - c. contacting emergency services and/or Service police and securing the incident scene following death by suicide, deliberate self-harm or harm to others.¹⁰⁶
97. Specifically, commanders must refer a Defence member, considered to be at risk, to a Defence medical officer or mental health professional for immediate assessment.¹⁰⁷
98. Chaplains also have an important role in providing support to Defence members. Chaplains are responsible for using their pastoral, theological and mental health training to:
- a. counsel, support and provide pastoral care to Defence members
 - b. refer Defence members to mental health professionals for appropriate risk assessment and support
 - c. assist Defence members to access emergency services
 - d. support a member with a crisis management plan, or support development of a crisis management plan
 - e. support commanders to carry out their responsibilities in relation to Defence members at risk
 - f. encourage commanders to involve Defence members in the mental health programs delivered by Joint Health Command.¹⁰⁸
99. Families also play an important role in encouraging help-seeking and supporting treatment and recovery. We have heard about instances where family members have not been told about their loved one's suicide attempts or mental health distress. We discuss the importance of families in Chapter 27 and issues concerning privacy and information sharing in Chapter 16, ADF healthcare services.

Suicide risk assessments

100. Comprehensive risk assessments are used to determine a serving member's level of risk for suicide, self-harm or harm to others. Defence medical officers and mental health professionals are responsible for determining which members receive a risk assessment based on a clinical presentation and known circumstances.¹⁰⁹
101. The risk assessment is intended to inform clinical treatment and management of the individual and is to be conducted by a mental health professional in accordance with the Defence Health Manual guidelines.¹¹⁰
102. The risk assessment is designed to explore a range of factors, including:
- the frequency, recency, severity and lethality of previous relevant behaviours
 - the frequency, intensity and persistence of ideation and the likelihood of the member to act
 - the member's level of planning and resource preparation, the availability and lethality of means, and the member's intention to act
 - additional notable risk factors, including mental ill-health, and stressors
 - substance use and misuse
 - accessibility of family, peers, chain of command and other service providers to the member
 - and other protective factors.¹¹¹
103. According to the Defence Health Manual, a risk assessment should provide the treating medical officer or mental health professional with:
- a. an indication of the Defence member's:
 - (1) level of risk of suicide, self-harm and/or harm to others...
 - (2) willingness to engage in treatment
 - (3) mental capacity to make decisions about consent to treatment
 - b. information:
 - (1) regarding any underlying mental health disorders
 - (2) regarding the development and course of the member's condition
 - (3) to enable identification of treatment and management strategies.¹¹²

The problem with suicide risk assessments

104. Many studies have identified that suicide risk assessments on their own can be ineffective – or worse.
105. In 2021, the Australian Commission on Safety and Quality in Health Care produced its *Final Report – Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*. The ineffectiveness of suicide risk assessments, in both ADF and civilian health settings (including in acute emergency settings), was a recurring theme in the report. The authors noted, about serving members who had died by suicide, that when such assessments had been conducted ‘they were sometimes either inappropriate or inaccurate’, adding:¹¹³

It appeared many people in the cohort had received a suicide risk assessment at some point, although a significant minority of the cohort was assessed to be at ‘low’ or ‘moderate’ risk of suicide, often in close proximity to a previous suicide attempt, or shortly preceding their death.¹¹⁴

106. Based on the cases the review analysed, the authors noted several possible reasons for this, including:
- serving members concealing information due to concern it would impact their opportunity for deployment or continued ADF career¹¹⁵
 - limited knowledge on the part of civilian health providers of an individual’s ADF history, past treatment and therapies, and extent of previous suicidal ideation¹¹⁶
 - limited objectivity in the application of suicide risk assessment tools, and/or conflicting interpretation of results, especially in acute care settings.¹¹⁷
107. As the report notes, suicide risk assessment tools have long been shown to be problematic for predicting the true extent of the risk of intentional self-harm. This is not an issue specific to the military context, but rather one that is common and well known in the wider mental health sector.¹¹⁸
108. Multiple international and Australian jurisdictions now advise against using risk assessment tools alone to predict suicide. For example, the New South Wales policy directive, the *Clinical Care of People Who May Be Suicidal*, has advised that the use of screening tools alone ‘must not be used to assess risk or determine treatment’.¹¹⁹
109. This is because risk factors alone cannot identify people experiencing suicidality with certainty, and because suicide risk is not static. Rather, risk increases and decreases with time and circumstances, which means an ongoing process of assessment and management is necessary in any instance.

110. For suicide risk assessment and management to be implemented effectively, it is reliant upon a number of factors:
- the judgement of the clinician and their experience
 - clinical presentation of the client and assessment and management options available at their health service
 - communication from the client.¹²⁰
111. There may be circumstances in which members find it difficult to discuss the full extent (or any) of their suicidal thoughts and feelings. This can make the assessment of risk more difficult, but the assessing practitioner needs to be alert to this possibility.
112. Studies have highlighted the benefit of safety planning interventions for suicidal behaviour, with some research showing safety planning reduced risk for suicide-related behaviours.¹²¹ Safety planning helps identify instances of ideation and creates strategies for coping and support if an individual finds themselves experiencing suicidality.
113. Mr Alan Woodward, former National Mental Health Commissioner, described safety planning to us:
- One of the areas of service improvement in suicide prevention over the last decade or so has been in the area of what is called broadly safety planning. It was developed [...] as an added tool to those working in crisis intervention, like helplines or community crisis centres, to engage with the person around, after de-escalating the immediate suicidal crisis, what can be done to keep that person safe should that crisis level again start to rise. ... Safety planning is a tool that can be used to engage people around [the question of] how do we wrap around this person and provide support and safety, often in the knowledge that the more deep-[seated] issues surrounding their suicidal thoughts and despair will take some time to address.¹²²
114. We are concerned that, used in isolation, suicide risk assessments are an inappropriate way of properly identifying those in need of support. We are further concerned that, used improperly, they may in fact heighten members' risk of suicide.
115. Defence has advised that they do still use risk assessments, and categorise risk as either low, medium or high, for the purpose of notifying commanders when a member under their command is assessed as being at such a risk.¹²³
116. However, we acknowledge and welcome a shift in ADF's current risk management approach.
117. In November 2021, Defence partnered with SafeSide Prevention to implement a three-year project designed to strengthen the SPP. This includes training for medical officers and mental health professionals who are required to undertake suicide risk

assessments.¹²⁴ The SafeSide Framework focuses on planning interventions, rather than predicting the risk of suicide.¹²⁵ This will align Defence's risk assessment and management approach with best practice.

Acute and emergency mental health and suicidal crisis care

118. Throughout our inquiry, we heard lived experience accounts of inadequate care at times of suicidal crisis.
119. The Defence Health Manual sets out the steps taken when an ADF member is determined to be at risk of suicide, self-harm and/or harm to others. The manual outlines the roles and responsibilities of, and actions to be undertaken by, responding personnel, command and management, medical officers, mental health professionals and chaplains.¹²⁶
120. According to the manual, Defence members assessed to be at high risk of suicide and self-harm should be managed either as inpatients in off-base facilities or as in/outpatients at a Defence health facility, as clinically appropriate.
121. When deciding whether to use garrison or off-base facilities, the treating medical officer or mental health practitioner is to consider:
 - risk factors
 - protective factors
 - the garrison health facility's capacity
 - the Defence member's mental capacity for decision-making
 - the Defence member's willingness to receive support or treatment
 - the expected impact on the Defence member of each treatment approach.¹²⁷
122. For those members requiring off-base inpatient care, the assessing or treating medical officer or mental health practitioner is to:
 - a. arrange referral for admission to an off-base facility ...
 - b. ensure the Defence member is observed at all times until handover to the off-base facility occurs (this should include an assessment of any items that could compromise the immediate safety of the member or others)
 - c. contact emergency services, civilian police or Service police if a Defence member is at immediate risk
 - d. notify the member's commander and trigger an Individual Welfare Board (IWB) when practicable.¹²⁸

123. An ex-serving member who made a submission to the Royal Commission told us he felt he had been 'dumped' at hospital:

At the start of August, I was admitted to [redacted] Hospital, to their mental health ward. I was told by the base [Adjutant] to pack a bag as I was going to hospital again. So I packed a back pack of a few bits of clothing and that was all. I didn't know where the taxi was taking me other than 'a hospital'. When I was being shown around the ward by one of its d[octo]rs, that's when I realised it was a mental health ward and I felt like I was crazy or nuts as I was sent to a psych ward without knowing. When I rang base and spoke to the [Adjutant], he told me to stay there and that if I left I would be charged with AWOL ... I spent 4 weeks there. My mates would not return my calls or messages and I heard from no one. During my time on the ward, I never heard from anyone from the army. I had been dumped at the hospital and left there. My mental health continued to get worse despite being in a place that was meant to be helping me. After 4 weeks and many phone calls I returned to base. I asked my mates why they were ignoring me and they said they had been told by our platoon commander to not contact me and to not respond to me if I tried to contact them.¹²⁹

124. According to Defence policy, the off-base facility will manage the member until the risk level has been assessed by a specialist as having decreased sufficiently to warrant discharge and outpatient management. The treating Defence medical officer is responsible for liaison with the facility to facilitate clinical handover.¹³⁰

125. If an off-base facility does not accept the member for admission, possibly due to a different risk assessment, or no beds being available, the treating Defence medical officer should:

- a. where clinically indicated, arrange to have the Defence member temporarily admitted to a Defence health facility while securing admission to an off-base facility in another region
- b. document the process and risk assessment that led to the admission of the member to a Defence health facility
- c. if required, seek support through the senior medical officer, regional medical adviser or commanding officer joint health unit
- d. continue to manage the member in accordance with the high or medium risk procedures.¹³¹

126. These situations can be difficult both for the member and for the garrison health facility, which may not be equipped to manage the crisis.

127. Often, the off-base facilities used in crisis situations are emergency departments, which pose several challenges to the provision of care in a suicidal crisis. These challenges include lack of privacy, short triage times and level of staff experience and confidence in assessing and managing suicide-related presentations.¹³²

128. ADF members may experience further challenges, such as the lack of military cultural competency in the attending mainstream health practitioners. In Chapter 18, Health care for ex-serving members, we make a recommendation about building the military cultural competency among health workers who operate in the mainstream health system.
129. In their submission to us, a mental health professional contracted to Defence provided a perspective on the challenges associated with finding suitable care for members experiencing crisis:
- Should we need to seek a hospital admission for an acute presentation or containment of risk, the options were very limited. First preference being a private facility whose admission waitlist was lengthy, usually out of location from the members family and often delayed due to the sheer amount of paperwork/funding approvals required between the facility and Defence. If the matter was more acute, the public hospital system would be used – an unfortunate necessity in some cases, however, [as this is] usually even more traumatising for the member. The lack of Defence health facilities specifically for [mental health] in some states is surprising, given the inadequate resources and increased demand for [mental health] support and clinical services.¹³³
130. We are aware of work by government and non-government organisations to establish alternatives to emergency department presentations at times of suicidal crisis. This includes ‘safe spaces’ and other services where care and support are often provided by a peer worker in a non-clinical environment.¹³⁴
131. There is a need for Defence to consider how these spaces could be leveraged or replicated for ADF members and veterans. This may also be relevant to first responder roles.

Protocols for managing suicide attempt and self-harm in ADF have not always been followed

132. As with so much of the Defence Health Manual’s mental health guidelines, the processes appear appropriate on paper. However, an audit by the ADF’s own mental health agency found serious shortcomings with how the suicidal crisis system works in practice.
133. In 2017, the ADF Centre for Mental Health conducted a quality assurance audit into the clinical and administrative management and monitoring of suicide attempts and self-harm by ADF members. The audit specifically covered the period between the rollout of the Defence Electronic Health System in 2014 and October 2016.
134. The ADF Centre for Mental Health identified a total of 147 members who engaged in a suicide attempt or self-harm in that period, of which a representative sample of roughly 10% were chosen to be analysed.

135. Using a set of civilian and ADF clinical standards developed for the purpose, auditors examined the individual health records of the selected personnel and assessed their compliance with the civilian and ADF standards.¹³⁵
136. The audit found that while the management of these members was found to be 'generally compliant' with both sets of standards, they were more often more compliant with the civilian ones than those of the ADF, which 'varied significantly'.¹³⁶ None of the cases analysed were fully compliant with ADF standards and two were found to be minimally compliant.¹³⁷
137. The audit found cases of minimal compliance, including:
- In one case of minimal compliance, a member who was well known to the team at his health centre because of a pre-existing mental disorder presented with self-harm. While he was immediately admitted to a private psychiatric facility for specialist care, no Comprehensive Assessment and Management Plan [...] was completed (in particular there was no mention of a risk assessment by the medical officer (MO) the day after self-harm had been treated at a civilian emergency department), no Individual Welfare Board (IWB) was convened, and no Crisis Management Plan or Mental Health Safety Plan were raised.¹³⁸
138. The auditors suggested that the civilian standards were easier to adhere to on the grounds that there they were 'more general and are based on broad principles of care,' whereas ADF standards 'are more technical'. They asked:
- The question is whether the ADF is prepared to provide adequate resources to the level required for complete compliance or whether it is satisfied with the standard described in this audit.¹³⁹
139. According to documents we received from Defence, improvements have been made since the 2017 audit. This includes improvements in standardised data collection by ensuring correct use of consistent medical terminology (SNOMED code selection), and upskilling of health staff.¹⁴⁰ We are unsure whether a more recent audit has been undertaken, or if any amendments to protocols were made as a result of the 2017 audit.
140. We cannot emphasise more strongly the importance of effective treatment and support for an individual experiencing suicidal crisis. Just as important is the provision of high-quality aftercare for reducing suicide risk.

17.2.3 Aftercare in the ADF

141. Aftercare is the 'support provided to individuals who have recently made a suicide attempt, for the purposes of increasing access to and engagement with care providers and preventing repeated self-harm'.¹⁴¹
142. The ADF does not currently have any policies or procedures that refer to 'aftercare' and the term 'aftercare' does not appear in the Defence Health Manual.¹⁴²

143. When we asked Defence about their aftercare policies and procedures, they referred us to the general policies and procedures that relate to the provision of support to members at risk of suicide, which they say includes members who have made a recent suicide attempt.¹⁴³
144. Our assessment is that these policies and procedures need to be strengthened with regard to supporting members who have recently made a suicide attempt. They appear to focus mostly on risk assessment and managing risk. Consequently, there is a lack of guidance on the provision of personalised recovery support, and reintegration into the workplace following a suicide attempt.
145. The Defence Health Manual states, in the case of managing a member at risk of suicide, the need for continuous supervision and support, and contacting of emergency services and support is needed.¹⁴⁴
146. Additionally, it states there is a requirement for the incident to be reported 'to the commander or manager of the Defence member at risk, or their own commander or manager where this is not practical.'¹⁴⁵
147. It also states that the commander must convene an Individual Welfare Board to ensure the 'immediate safety and needs of a Defence member at risk of suicide are met'.¹⁴⁶ Defence has told us that Individual Welfare Boards are intended to deliver a tailored individualised response to the management of a member with complex needs.¹⁴⁷
148. Apart from standing up an Individual Welfare Board, the relevant policies and procedures appear to be silent on the support that is to be provided to an individual following a suicide attempt.
149. We also did not find any evidence of guidance for commanding officers on how they can best support a member reintegrate into work following a suicide attempt.
150. We received one submission from a lived experience member who spoke of being given time off, but had little to no contact or support from their commanding officers during the time off.¹⁴⁸
151. We think the lack of procedures and guidance specific to aftercare is a significant omission given what we know about a previous suicide attempt being one of the greatest risk factors for suicide death. Quality aftercare is crucial to aid recovery and support a member to return to their work in a safe, person-centred manner.
152. Defence must do more to ensure it has appropriate protocols in place, in terms of responding to suicidal crisis and delivering high-quality aftercare. At the time of writing, we are aware that Defence is updating several of its policies and procedures that it considers relevant to aftercare. According to Defence, this will include a 'process of unifying the documentation of an ADF-wide policy on welfare board management'.¹⁴⁹ We have not seen these updates so are unable to judge whether they align with best practice and address the issues we have identified.

Recommendation 70: Revise protocols for responding to suicidal crisis to be in line with clinical best practice

By no later than 31 December 2025, Defence should revise its protocols for responding to suicidal crisis so they are applied consistently, in line with clinical best practice.

- (a) The protocols should, among other things, specify:
 - (i) the availability of, and arrangements for accessing, culturally appropriate crisis care facilities
 - (ii) a minimum standard for aftercare
 - (iii) how monitoring and follow-up support should occur following a suicide-related incident
 - (iv) approaches to reintegration following a suicidal crisis.
- (b) The revised protocols should be developed in partnership with an external body with expertise in managing suicidal crisis and aftercare.
- (c) The revised protocols and their application across the three services should be subject to independent evaluation after five years.

17.3 Suicide prevention for ex-serving members

153. In Part 6 of this report, Transition and support for ex-serving members, we discuss systemic issues that we have identified as contributing to increased risk of suicide among ex-serving members. There we examine the effectiveness of current wellbeing supports, including the support offered by DVA to claimants and clients. We also review DVA's claims processes and its organisational culture.
154. The purpose of this section is to outline the specific suicide prevention initiatives and programs provided by DVA.
155. DVA, by way of its purpose and functions, is in contact with vulnerable and potentially at-risk veterans. DVA therefore has a critical role in suicide prevention and proactively identifying and addressing risk factors among their clients.

17.3.1 Overarching strategies

156. DVA's guiding document in relation to suicide prevention has been its *Veteran Mental Health and Wellbeing Strategy and Action Plan 2020–23*.¹⁵⁰ This will be superseded by the joint *Defence and Veteran Mental Health and Wellbeing Strategy 2024–29*, which is due to be finalised in June 2024.¹⁵¹ The new joint strategy is discussed in detail in Chapter 15, Promoting health and wellbeing among ADF members.
157. We note that the *Veteran Mental Health and Wellbeing Strategy and Action Plan 2020–23* includes a number of objectives that focus on suicide prevention and supporting at-risk individuals. These include:
- (i) Objective 1.3 – Apply evidence-informed suicide prevention programs based on lessons from trials and broader government plans, and new approaches that support veteran wellbeing.
 - (ii) Objective 1.5 – Address barriers to accessing care for veterans and their families, prioritising those at high risk of adverse mental health and wellbeing outcomes.
 - (iii) Objective 2.5 – Improve identification of at-risk transitioning members and enhance tailored strategies for them and their families to improve their transition experience.
 - (iv) Objective 3.6 – Apply shared knowledge and research outcomes, experts, researchers and providers, to ensure evidence informs approaches to improving veteran mental health and wellbeing, and reducing suicide.¹⁵²

17.3.2 DVA suicide prevention initiatives and programs

158. We asked DVA to identify which actions in the *Veteran Mental Health and Wellbeing Strategy and Action Plan 2020–23* were specifically focused on suicide prevention. They identified several actions, which we discuss here.

The Veteran Suicide Prevention Pilot

159. Between 2018 and 2020, DVA funded the Veteran Suicide Prevention Pilot in response to the 2017 National Mental Health Commission's *Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families*.¹⁵³
160. The pilot aimed to evaluate the benefits of providing intensive, coordinated support and non-clinical management services to address a veteran's mental health and wellbeing needs on discharge from hospital following a suicide attempt or suicide ideation.¹⁵⁴ Veterans clinically assessed as being at increased risk of suicide were also included in the pilot.¹⁵⁵

161. The pilot involved DVA contracting Beyond Blue to adapt its existing *Way Back Support Program* to a veteran-specific context.¹⁵⁶ This provided a non-clinical outreach service that aimed to support continuity of care by providing tailored psychosocial support to individuals directly after a suicide attempt or suicidal crisis.¹⁵⁷
162. Phoenix Australia was engaged to provide an independent evaluation of the pilot in 2020. The results of the evaluation were not positive. It found that there were issues with missing data, barriers to access and low uptake, and no reduction in suicidal behaviour.¹⁵⁸
163. In February 2021, DVA agreed that the pilot would transition to the Open Arms Community and Peer Program, which includes lived experience peers working collaboratively with veterans, family supports, community agencies and mental health clinicians.¹⁵⁹

Suicide intervention training initiatives

164. During the period July 2017 to June 2023, DVA delivered a suite of mental health literacy and suicide prevention training initiatives to veterans, their families and the wider veteran community.¹⁶⁰
165. According to DVA, the suite of suicide prevention training initiatives included:
- a. *Applied Suicide Intervention Skills (ASIST)*: ASIST is a two-day face-to-face workshop providing advanced suicide awareness, prevention, intervention and response skills and knowledge.
 - b. *ASIST Tune Up*: This was a half-day refresher training course for participants of previous ASIST training that covered suicide awareness, prevention, intervention and response skills and knowledge. It was developed for participants seeking to refresh their knowledge.
 - c. *SafeTALK*: This is a half-day training program option that helps participants to identify veterans at risk and link them into supports.
 - d. *SafeTALK for Veterans (Pilot)*: This was a veteran-tailored version of the SafeTALK suicide intervention training. The pilot was designed to be a one-day program using veteran-specific scenarios and tailored to veterans, their families and the veteran community. The workshop ran twice in September 2020 as a pilot.
 - e. *Suicide Prevention START*: This was a 60- to 90-minute self-paced, online option for suicide awareness training.¹⁶¹
166. We note that three out of the five initiatives are no longer offered, and in two of these cases, the initiatives ceased due to lack of funding. We agree that ineffective programs should not be allowed to continue. However, we are not certain whether any formal evaluation occurred and whether this informed the decision to cease the programs.

Other DVA initiatives

167. DVA also identified further actions. These are summarised in Table 17.1 together with DVA's update on their implementation status.¹⁶²

Table 17.1 DVA's suicide prevention actions and their implementation

Action	Implementation update
Build the capability to triage and investigate incidents of suspected and attempted suicide in the veteran community.	DVA has developed a new risk framework to ensure a consistent approach to the identification of risk. DVA also has an Adverse Events Analysis program in place to analyse individual cases where there has been a death by suicide, to identify any issues with DVA's systems and processes. ¹⁶³
Enhance Open Arms's suite of suicide prevention offerings, including developing, piloting and evaluating a one-day veteran-specific suicide awareness and prevention training package.	Open Arms previously contracted LivingWorks to modify its safeTALK program into a one-day veteran-specific suicide prevention workshop, to be delivered as a program pilot. The service delivery contract with the current provider LivingWorks ended on 30 September 2022. ¹⁶⁴
Operationalise the SafeSide risk prevention framework – a best practice approach to suicide risk assessment within Open Arms.	As of October 2023, 482 Open Arms and DVA staff have been trained in the SafeSide Framework. ¹⁶⁵
Scope options to better support family members supporting a veteran through suicidal crisis or following a suicide attempt.	DVA is establishing web-based forums to assist veterans and their families and is also developing enterprise-wide lived experience and postvention frameworks. ¹⁶⁶
Consider opportunities to leverage advice from the National Suicide Prevention Adviser and the work of the National Suicide Prevention Office. This advice could help better identify risk factors that may contribute to suicidal behaviour in veterans and their families, especially during transition. It would inform development of a DVA-wide approach to lived experience engagement with veterans and families.	According to DVA, this expertise is informing its work in suicide prevention, including the development of the <i>Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029</i> . ¹⁶⁷
Progress delivery of the national program of mental health and suicide prevention/intervention training. This will help up to 7,000 volunteers recognise people at risk and offer intervention and support, through the partnership between Open Arms and the Returned and Services League of Australia (RSL).	The following workshops are being delivered around all regions via Open Arms–accredited trainers: SafeTALK, Applied Suicide Intervention Skills Training, Mental Health First Aid training. ¹⁶⁸
Collaborate with peak health bodies and health professionals to ensure a best practice approach to improving veteran mental health and wellbeing, and reducing suicide.	DVA has advised that it offers online training to GPs and mental health clinicians. ¹⁶⁹

Action	Implementation update
Deliver annual data and reporting updates of national suicide monitoring of serving and ex-serving ADF personnel, in partnership with the AIHW. This will inform improvements in veteran mental health and suicide prevention.	The sixth report was published on 21 November 2023. ¹⁷⁰

Non-DVA initiatives

The National Suicide Prevention Trial

168. The National Suicide Prevention Trial took place in 12 Australian regions from 2016–17 to 2020–21. The Australian Government Department of Health and Aged Care funded Primary Health Networks in each of these regions to ‘develop and implement a systems-based approach to suicide prevention at a local level for at-risk populations’.¹⁷¹
169. The Townsville trial, called Operation Compass,¹⁷² focused on reducing rates of suicide among ex-serving members and their families.¹⁷³
170. The program modelled a multilevel systems approach to suicide prevention grounded in local and community engagement, aligning with the *Veteran Mental Health and Wellbeing Strategy and Action Plan 2020–23*, and offered community grants for smaller initiatives, lived experience workshops, and gatekeeper and other mental health training to community stakeholders.¹⁷⁴
171. Mr John Caligari AO DSC, Chair of The Oasis Townsville, which housed Operation Compass in that city, explained that multilevel approach to the Royal Commission as follows:
- [W]hat we found was if you ask the veteran community what ideas do they have that might help in the reduction of suicide or the reduction of mental health issues, everyone has an idea. Some of those ideas are very small ideas. It could be adopt a particular app ... Or it could be something big like a communications campaign, which involves many layers ... [W]e literally had hundreds and hundreds of ideas, some of which fitted into other ideas, so we were able to roll them up. We actually, in the end, created six campaigns and each campaign, whether it was the evidence-based campaign or the data campaign or the connections campaign, it was about putting them into logical frameworks to be able to then bring them all together and put them at the correct level in order to analyse them.¹⁷⁵
172. In 2020, Operation Compass begun its evaluation phase. Its initiatives were transferred to organisations and institutions that could continue them, with those remaining transferred to The Oasis Townsville on 1 July 2020. The Oasis Townsville Operation Compass trial was completed at the end of 2022.¹⁷⁶

173. Initiatives undertaken as part of the Operation Compass trial included:

- #CHECKYOURMATES, a social media campaign to encourage ex-serving members to check in on their peers and their wellbeing
- a peer worker initiative, with trained ex-ADF members with lived experience of suicide. This initiative was then adopted more widely by Open Arms¹⁷⁷
- the Suicide Prevention Toolkit, created by Black Dog Institute and The Oasis Townsville to support Primary Health Networks to deliver more targeted and responsive services to serving and ex-serving members
- veteran health training for GPs, to 'improve knowledge, skills and confidence in Defence veteran health consultations'
- veterans' HealthPathways, which help GPs to support former and transitioning ADF members to navigate the mainstream civilian healthcare system
- community grants, which supported small-scale veteran organisations and trusted community groups to deliver wellbeing and resilience projects.¹⁷⁸

174. No aftercare services were involved in Operation Compass, 'in keeping with an overall focus of the [s]ite on "upstream factors" and due to concerns about the sustainability of new services at the conclusion of the [t]rial'.¹⁷⁹

17.3.3 How does DVA support at-risk and suicidal clients?

175. We think it is critical that DVA has robust processes in place to ensure it can consistently identify risks and escalate them to the appropriate referral points. DVA's own reviews of deaths by suicide among DVA and Open Arms clients (Adverse Event Analysis) have previously identified shortfalls relating to this issue.

176. In 2019, as a result of two Adverse Events Analysis reviews, DVA identified a number of areas for improvement. These included:

- develop and implement standardised risk criteria and a framework to effectively identify, assess and manage at-risk clients
- define the model of care available to support at-risk, complex and vulnerable clients within the Client Support Framework.¹⁸⁰

177. DVA has advised us of the action it has taken in response to the identified areas for improvement. This is summarised below.

Detection of risk indicators

178. According to DVA, it now has a nationally consistent approach to risk identification, assessment and mitigation.¹⁸¹ The Client Support Program Risk Framework covers three risks:

- harm to self
- harm to others
- suicide.¹⁸²

179. There are risk tools for non-clinical and clinical staff, and staff receive training in the tool relevant to their role.¹⁸³

180. Cases are escalated to the senior clinician where any factors are unable to be resolved or moderated within reason, resulting in the case:

- being unstable
- having an elevation in risk to self, others or reputation
- having no clear plan to address the factors
- that the factors identified would be reasonably considered to be within the scope of DVA to address.¹⁸⁴

181. In section 17.2.2, we discuss the challenges with suicide risk assessments. However, we acknowledge that DVA has, like the ADF, moved to strengthen its approach to risk assessments, and is now implementing the SafeSide Framework.

Client support framework

182. DVA's Triage and Connect Intake and Assessment acts as a centralised referral point to ensure timely and appropriate support for clients and their families who require additional support due to risk, vulnerability or complexity factors.¹⁸⁵

183. The range of circumstances in which a client may be referred to Triage and Connect Intake and Assessment is not limited. DVA staff are encouraged to refer any client to Coordinated Client Support Branch when certain indicators are present, and/or intervention is needed to ensure the client receives the right support at the right time.¹⁸⁶

184. Triage and Connect Intake and Assessment referrals are triaged by Coordinated Client Support on the day of receipt to determine response and timing as follows:

- a. Immediate risk – refer to Emerging Welfare Events team for same day response
- b. Significant risk factor/s – allocated for same day response
- c. Priority/risk indicator present alongside protective factors – allocated to case manager for response within two days
- d. Routine – allocated to case manager within five days.¹⁸⁷

185. Where a staff member identifies immediate risk, for example threats of self-harm, suicide or serious concerns about a client's safety or wellbeing, a referral is made to DVA's Emerging Welfare Events team. A clinically trained team member independently assesses and prioritises each referral.
186. DVA does not provide any clinical crisis intervention. Where there are concerns for the veteran's immediate safety, DVA will contact emergency services.¹⁸⁸
187. Open Arms, despite maintaining a 24/7 help line, does not provide crisis care. Its model of care states that it does not provide specialist assessment and intervention for individuals, including those at significant risk of suicide or self-harm.¹⁸⁹ However, it 'may have a supporting role', including to help clients 'navigate through' the health system or to seek acute mental health services.¹⁹⁰

17.3.4 DVA's approach to aftercare

188. We asked DVA to provide information about its current policies and procedures related to aftercare.¹⁹¹
189. In response, DVA said 'DVA does not deliver any programs directed expressly to the specific purpose of providing aftercare'.¹⁹² DVA instead pointed us towards information on its programs to identify vulnerable clients and connect them with support.¹⁹³
190. We think DVA should have a procedure to guide the support provided to clients following a suicide attempt. We urge that this is considered as part of the development of the Suicide Prevention Action Plan that will sit under the *Defence and Veteran Mental Health and Wellbeing Strategy 2024–29*.

17.3.5 Conclusion

191. DVA deals with complex clients and people with high needs. In our view, there is more it can do to support the wellbeing of veterans, reduce risk factors for suicide and foster protective factors.
192. When we reflect on the *Suicide Prevention Standards for Quality Improvement* described earlier in section 17.1.2, we suggest that there are opportunities for DVA to better align its suicide prevention initiatives with best practice. For example, we note the absence of a specific suicide prevention strategy. While there are clearly initiatives being undertaken by DVA, we think they would benefit from greater coordination, evaluation and continuous improvement, and articulation of how they work together to meet the needs of the veterans.
193. In Chapter 24, Empowering veterans to thrive, we make several recommendations that address the drivers of suicide and suicidality among veterans. One significant reform that we recommend is for the establishment of a new veteran wellbeing agency. We propose a set of functions for the new agency that would foster protective factors against suicide and suicidality, as described below.

- Transition – Play a key role in the transition program for veterans, build relationships and encourage veterans to access early interventions and supports.
 - System navigation and connection to wellbeing supports – Help veterans to navigate the wellbeing ecosystem by providing clear information about available services. In the context of this chapter, this is especially relevant for connecting veterans to crisis care, when required.
 - Co-design wellbeing supports – Work with veterans to co-design new prevention and early intervention wellbeing programs and services at the local level.
 - Leverage veteran wellbeing hubs and expand engagement – Work in partnership with established hubs and expanding engagement with veterans through state and territory shopfronts.
 - Improve referral pathways and service integration – Being the relationship manager between hubs, DVA, Australian and state and territory government agencies, and funded providers to ensure referral pathways are in place and services are integrated to the greatest extent possible. This should include advising DVA and state and territory governments on identified service gaps.
194. DVA must also ensure veterans can smoothly and easily navigate DVA's claims processes, and that administrative practices and poor customer service do not exacerbate veterans' pain and suffering or hinder their access to support. We note recent initiatives introduced by DVA to increase assistance to veterans lodging a claim, and make recommendations to strengthen advocacy support in Chapter 26, Supporting DVA claimants and clients.

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18 Health care for ex-serving members

Summary

This chapter considers ex-serving ADF members' experiences when accessing and receiving health care after transitioning from military service.

In Chapter 14, Introduction to health care for members and veterans, we discussed how health care can influence the mental health and suicidality of serving and ex-serving members. With this in mind, it is important that veterans can access health care that is adequate, timely and accessible, and is provided by practitioners who understand the veterans' experience and military culture.

This chapter provides an overview of the veteran health care system and existing initiatives that aim to improve veteran health.

It will discuss issues we observed with the veteran health system, including:

- a lack of awareness of the health system's complexity
- poor health literacy among ex-serving members
- poor continuity of care following separation
- supply issues affecting access to timely and affordable care
- shortcomings in providing health care informed by an understanding of veterans' needs
- issues with data sharing.

We propose measures to address these issues, including:

- changing the fees health providers are paid to see clients whose care is funded by the Department of Veterans' Affairs, to make it more attractive to provide health services to veterans
- the development of 'networks' of care to improve access to, and coordination between, specialised healthcare services for veterans and other healthcare services.

18.1 Introduction

1. Serving members access health services through centres located on Defence bases throughout Australia, as we discussed in Chapter 16, ADF healthcare services. If they need specialist health care, it is provided through a range of off-base health facilities and providers.
2. However, once they leave permanent Australian Defence Force (ADF) service, ex-serving members lose access to the Defence healthcare system. Those who transfer to the reserves may retain some access, but otherwise ex-serving members must use Australia's civilian healthcare system, with only a few specialised veteran services.
3. In this chapter, we use the word 'veteran' to refer to ex-serving members, reflecting the terminology used by some of the healthcare programs that we talk about.

18.2 Veteran health care

4. Ex-serving members must access a civilian healthcare system that is complex: a 'multifaceted web of public and private providers, settings, participants and supporting mechanisms'.¹
5. This can prove challenging for people who are not familiar with the system.

18.2.1 How is health care provided to veterans?

6. Health care for veterans is multifaceted and involves multiple actors.
7. Funding for eligible veterans' health care is the responsibility of the Australian Government, through the Department of Veterans' Affairs (DVA). It does this through a range of DVA veterans' healthcare programs, which are described in more detail in section 18.2.2. These fall under two broad categories: liability and non-liability.²
8. Liability-based programs involve DVA paying for health care in relation to certain eligible conditions acquired during service. To access such a program, a veteran must lodge a claim with DVA. DVA then determines liability – that is, whether the ex-serving member has an eligible condition and whether it is linked to service.³
9. Non-liability programs allow eligible veterans to access health care for certain conditions without having to demonstrate a link to service.⁴
10. Health services themselves are mostly delivered through the mainstream health system: hospitals, GP clinics and other health providers operated by the public, private and community sectors.⁵ Limited veteran-specific health services are delivered by the Australian Government (through Open Arms), some state and territory governments and the community sector.

11. In addition to these veteran-specific programs, veterans (like other members of the Australian public) can access health care using Medicare, private health insurance or by self-funding.⁶ They may also be eligible for discounted care through other concessional schemes.⁷

18.2.2 DVA healthcare initiatives

Liability health care through veteran health cards

12. Veterans can use the DVA claims system to access entitlements for certain conditions sustained during service. It enables claims for lost income and compensation, which we discuss in more detail in Chapter 25, Entitlements and claims processing.⁸
13. Through this process, veterans can also access funding for health care, including medical treatment, rehabilitation and other health services. Funding is provided through veteran health cards, which are described below.⁹
14. To access liability health care through a veteran health card, ex-serving members must go through the claims process described in Chapter 25. During this process, DVA assesses whether the claim involves an eligible condition (an illness or injury), and whether this is related to the veteran's service.¹⁰ This is similar to the approach taken by other workers' compensation arrangements.¹¹
15. A claim will be assessed based on the relevant entitlement legislation (and its Statements of Principles, where applicable) that applies to the veteran, which depends on their service. We discuss the legislation and its application to the claims process in Chapter 25.

Types of veteran health cards

16. There are three types of veteran health card: Gold Card, Orange Card and White Card.
17. A Gold Card provides access to approved, 'clinically necessary' medical treatments for all medical conditions, including all mental health conditions. The treatment must be delivered in Australia.¹² The health condition or injury does not need to be from war service.¹³
18. A White Card:
 - covers approved medical treatments for injuries or conditions, where these have been accepted as service-related
 - provides access to non-liability treatment, including for all mental health conditions, for all veterans with continuous full-time service or certain reserve service.¹⁴

19. An Orange Card enables a veteran to access a concessional rate on prescription items like medicines and nutritional supplements at Australian pharmacies.¹⁵
20. DVA automatically issues a veteran health card to ex-serving members it finds are eligible for liability health care.¹⁶

Non-liability health care

21. DVA non-liability health care funds treatment for all mental health conditions. This includes fees for GPs, psychiatrists, psychologists, pharmaceuticals, hospital treatment and community-based treatment programs.¹⁷ Except for some co-payments for pharmaceuticals, this is at no cost to the participant.¹⁸
22. Veterans with a White Card can access non-liability mental health care immediately. Any current or former member of the ADF with at least one day of continuous full-time service is eligible for non-liability mental health care. Certain members of the reserves are also eligible.¹⁹
23. Veterans do not have to have made a claim or demonstrate a link between a mental health condition and their service to access non-liability health care with a White Card.²⁰ Since mid-2018, DVA has issued a White Card to eligible veterans on their separation from the ADF.²¹
24. Non-liability health care covers any mental health condition that is listed in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and the seventh edition of *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification*.²²
25. DVA has extended non-liability health care to a smaller group of eligible veterans for several physical conditions, including malignant neoplasm (cancer) and pulmonary tuberculosis.²³
26. DVA told us the non-liability health care program supports better health as it encourages earlier access to treatment:

Earlier [non-liability health care] access to DVA funded health care encourages people to receive treatment sooner. DVA recognise[s] that early intervention can have a positive impact when treating certain conditions. It can prevent further deterioration and complications.²⁴

Early Engagement Model

27. In 2016, DVA and Defence introduced the Early Engagement Model to ‘help DVA establish a relationship with an ADF member as early ... as practical’.²⁵
28. For members who joined the ADF from 1 January 2016, and those who separated after 27 July 2016, Defence now advises DVA when:
 - a member enlists
 - is involved in certain serious incidents
 - separates on medical or some administrative grounds
 - transitions from permanent service or
 - separates from the ADF.²⁶
29. Members are registered automatically with DVA, regardless of whether they have made a claim.²⁷ On separation, DVA contacts members and advises them of its services.²⁸
30. In 2021, DVA told the Royal Commission ‘DVA and Defence are working to continue to improve service delivery and claims processing through the [Early Engagement Model]’.²⁹ It noted there was ‘considerable scope to expand ... foundational data exchanges’ between Defence and DVA ‘to enable better and more pro-active transition and wellbeing support’. In 2023, it noted uncertainty around privacy law.³⁰

Veteran Support Officers

31. DVA Veteran Support Officers (VSOs) operate on 56 ADF bases across Australia, engaging with serving and transitioning ADF members.³¹ According to DVA, VSOs:
 - help ADF members and their families engage with DVA
 - provide support and advice based on the needs of individual members
 - deliver information on the services and supports available through DVA.³²
32. An Enhanced VSO Pilot (EVSOP) commenced in 2023. The pilot aims to help veterans who have complex claims or are seeking extra assistance to navigate DVA administrative processes. This includes support with paperwork and engaging with the claims process.³³
33. The pilot operates from two Veterans’ and Families’ Hubs (in Nowra and Perth) and ‘supports’ medical transitions in the ACT. It started on 31 July 2023, with initial funding to 30 June 2024.³⁴

Transition Medical Assistance Pilot Program

34. The Transition Medical Assistance Pilot Program began in 2022, operating at the ACT Health Centre at Duntroon. It assists medically transitioning ADF members by providing medical evidence to support their DVA claims.³⁵
35. According to DVA, the pilot program recognises transition ‘poses multiple stressors’ and that members separating on medical grounds may be ‘particularly vulnerable to increased stress’.³⁶
36. The program has a clinical team with direct access to the member and their Defence medical records. By helping members to provide ‘high-quality medical evidence’ to DVA, initial liability can be determined before separation, where possible.³⁷ It also involves engagement with healthcare providers to support care coordination during transition.³⁸
37. According to DVA documents from May 2024, the program has been extended to December 2024 ‘to allow further work to inform a business case’ to enable its expansion.³⁹

Coordinated Veterans’ Care program

38. The Coordinated Veterans’ Care program is for veterans who are at risk of unplanned hospitalisation.
39. An individual health plan is developed to support the veteran’s wellbeing and manage chronic conditions. It is delivered through a GP, a nurse coordinator and other health professionals.⁴⁰
40. Those with a Gold Card or a White Card with chronic DVA-accepted mental health conditions can access the program.⁴¹

Veteran Health Check

41. The Veteran Health Check program offers a GP-led health assessment to ex-serving members annually or as a one-off check.⁴²
42. The GP undertakes a comprehensive assessment to understand each veteran’s health needs. Veterans are asked questions on pain, sleep, post-traumatic stress disorder (PTSD), anger and physical health. If needed, they are referred for appropriate treatment, including through DVA programs.⁴³
43. Veterans who left the ADF from 1 July 2019 can access an annual check in their first 5 years after transition, but must produce their veteran health card.⁴⁴ All former serving members with at least one day of continuous full-time service, including reservists, can access a one-off check.⁴⁵ These members do not need to produce a veteran health card but may need to pay a Medicare gap fee, depending on the GP.⁴⁶

DVA engagement with Primary Health Networks

44. DVA informed us it began a collaboration with Hunter New England and Central Coast Primary Health Network (PHN) in 2022. PHNs are independent regional networks of health providers.⁴⁷
45. The collaboration aims to help develop new, veteran-specific 'HealthPathways'.⁴⁸ HealthPathways is an online health resource that can be accessed by GPs and other healthcare providers. It provides information, including on assessment, treatment and referral, that is based on evidence and adapted to local health contexts.⁴⁹
46. Since 2022, DVA and Hunter New England and Central Coast PHN, with the support of the Northern Queensland PHN, have developed resources for HealthPathways on such topics as referral, support and health assessment.⁵⁰ These resources have been shared with other networks, for localising and adoption.⁵¹
47. The 'collaboration contract' between DVA and Hunter New England and Central Coast network also cites other possible 'activities', including the development of education modules, and 'care navigation' resources to help individuals and families make decisions about their health.⁵²

Veterans' and Families' Hubs

48. The Veterans' and Families' Hubs are local centres that provide integrated services and support to ex-serving members and their families. They are discussed in more detail in Chapter 24, Empowering veterans to thrive.
49. Veterans can access physical and mental health support services at the hubs. The nature of the services differs depending on the location.⁵³ The hubs can provide referrals to other medical services and DVA services like Open Arms.⁵⁴
50. DVA is not involved in the management of the hubs.⁵⁵ However, it is responsible for administering grants and the funding arrangements for the capital costs in establishing them.⁵⁶

Open Arms

51. DVA operates Open Arms, which provides counselling and other mental health support services to serving and ex-serving members and Defence families.⁵⁷
52. DVA employs and commissions staff, including clinical staff, to provide Open Arms services.⁵⁸ This is unusual, not just among veteran health services but also among health services more broadly.⁵⁹
53. We have identified a number of issues with Open Arms, which we discuss in Chapter 19, Open Arms.

DVA rehabilitation services

54. DVA may fund rehabilitation services for veterans with an accepted service-related injury or illness. These services aim to promote ‘whole-of-person rehabilitation services to help them adapt to, and recover from, injury or illness related to their ADF service’.⁶⁰
55. Rehabilitation services do not include medical treatment.⁶¹ However, they do interact with medical treatment and other aspects of health care.
56. For example, DVA provides ‘medical management’ services: one of three categories of rehabilitation service.⁶² They are adjuncts to medical treatment and, according to DVA, could include:
 - coordinating medical providers to establish a treatment program
 - case management to help veterans attend medical appointments
 - assistance finding health providers, managing medicines or understanding medical information.⁶³
57. In section 26.3.1 in Chapter 26, Supporting DVA claimants and clients, we discuss DVA rehabilitation services. In Recommendation 101, we recommend enabling veterans to choose their rehabilitation provider, which should be supported by clear information about provider quality and service characteristics.

18.2.3 Other aspects of veterans’ health care

58. Ex-serving members use mainstream health services such as GPs and hospitals. These services can be funded through DVA or other programs such as Medicare. A number of providers offer ‘specialised’ services for veterans.

Access to ‘mainstream’ health services

59. As noted above, while veterans access DVA-initiated health care, they also access many of those delivered through the general Australian health system. This includes services delivered by states and territories, and the private sector.⁶⁴
60. Primary care, which includes care provided by GPs, is a central element of health care – the Australian Institute of Health and Welfare (AIHW) describes it as ‘often the first contact’ that a person has with the health system.⁶⁵ It is also key to veterans’ health care. DVA told us that, in 2022–23, more than 144,000 DVA clients accessed more than 1.4 million GP services⁶⁶ – and these figures only include veterans who accessed DVA-funded health care.
61. The National Hospitals Morbidity Database, which collects data from Australian public and private hospitals, shows that between 2019 and 2020, DVA funded 200,600 hospitalisations and Defence funded 10,700. Most were in private hospitals. In total, this represented 1.9% of all Australian hospitalisations.⁶⁷

62. Veterans can also access subsidies for medication. This can be through DVA or via the Pharmaceutical Benefits Scheme (PBS) available to all Australians with a current Medicare card. AIHW data shows that in 2017–18, more than 1 million medications were dispensed to around 70,000 ex-serving ADF members (who served between 1 January 2001 and 1 July 2017).⁶⁸

Specialised veteran health services

63. There is no ‘veterans’ health system’ as such: DVA is mostly a funder of services, which it commissions from mainstream health service providers including private health practitioners and state and territory health facilities.⁶⁹ However, as we note in Chapter 14, Introduction to health care for members and veterans, this was not always the case.
64. Following World War I, specialised health care for veterans was provided through ‘repatriation’ hospitals, operated by the Repatriation Commission. In 1989, the Australian Government decided to divest itself of repatriation hospitals and integrate them into mainly state but also some private hospital systems.⁷⁰
65. Vestiges of the repatriation hospitals remain in the form of specialised facilities and services for veterans. These are listed in Box 18.1. These play an important role, for example, in providing specialist care for veterans with complex health needs.⁷¹
66. Outside these facilities, there are some other providers of veteran-specific health care. In New South Wales, the St John of God Richmond Hospital in Sydney opened a Veterans’ Wellness Centre in August 2023, which offers physical and mental health services targeted at veterans and first responders.⁷²
67. Some private sector primary care facilities also offer veteran-specific services.⁷³ For example, the GO2 Health medical centre in Brisbane is a privately operated facility with a range of services targeted at veterans, including GP services, physiotherapy and psychology.⁷⁴

Box 18.1 Veteran health facilities

New South Wales

The National Centre for Veterans’ Healthcare at Concord Hospital in Sydney provides mental health, medical and allied health services for serving and ex-serving members.⁷⁵ Its services include case management, medical treatment, referral to allied health services, and dedicated accommodation for those who need to travel to access the service.⁷⁶

Queensland

Greenslopes Private Hospital in Brisbane provides a number of unique multidisciplinary services to veterans and war widows. They include the Keith Payne Mental Health Unit's PTSD Program, geriatric medicine and rehabilitation, and a dedicated stroke program for veterans.⁷⁷

South Australia

The Jamie Larcombe Centre in Adelaide provides mental health and PTSD services to ex-serving members from a specialist precinct located at Glenside Health Services campus. It offers inpatient and outpatient care, a PTSD group program, spiritual support and occupational therapy.⁷⁸

Following a major redevelopment, the Repatriation General Hospital at Daw Park, Adelaide was reopened as the Repat Health Precinct in 2020.⁷⁹ The precinct contains a dedicated Veteran Wellbeing Centre.⁸⁰

Victoria

The Veterans and Serving Members Unit is located at the Heidelberg Repatriation Hospital in Melbourne. Its services include trauma recovery, community recovery, transition support, and community rehabilitation (including hydrotherapy and the Kokoda Gym).⁸¹

Western Australia

The Ramsay Clinic Hollywood at Hollywood Private Hospital in Nedlands maintains a Recovery and Growth Program for veterans and serving members.⁸²

18.3 Issues with health care for ex-serving members

68. Our inquiry found a wide range of issues relating to health care for ex-serving members. One of the biggest issues is that once members leave the ADF, they move from a health system that is coordinated specifically for them to one with many players and in which they may lack support.
69. There are issues with the way information is provided to veterans, in terms of what is available to them, what they are entitled to and how they access it. There may be a lack of continuity of care after they transition out of the ADF and unnecessary hurdles in accessing care.

18.3.1 Low levels of engagement with DVA among some veterans

70. An AIHW report on the health of veterans found that, as at June 2021, approximately 240,000 ex-serving members were receiving DVA-funded pensions, allowances, treatment or pharmaceuticals.⁸³
71. The total number of veterans is much larger. In the 2021 Census, 496,276 people identified as ex-serving members of either the reserve or regular services of the ADF.⁸⁴
72. In Chapter 14, we note that 60% of ex-serving members report having a long-term health condition.⁸⁵ Not all conditions will be linked to service, and some long-term conditions may develop later in life. However, this means some ex-serving members with long-term health conditions may not be accessing DVA-funded care even if they are eligible.
73. Some witnesses shared these concerns with the Royal Commission. Professor Alexander McFarlane, Emeritus Professor of Psychiatry at the University of Adelaide, told us DVA is ‘missing a significant number of people who should be funded’ but are not.⁸⁶
74. The data is also concerning. Analysis undertaken by the AIHW showed that, among male ex-serving members who died by suicide between 2002 and 2021, only 29.1% were DVA clients.⁸⁷ Among female ex-serving members who died by suicide between 2002 and 2021, only 24.8% were DVA clients.
75. It is critical that veterans, particularly those who may be vulnerable, have access to care. Yet it has been suggested to us that ‘despite having easy access to funded care ... for mental health services, this is not being taken up by the majority of veterans’.⁸⁸
76. There are several reasons why veterans eligible to access DVA-funded health care may not do so. We were told:
 - Veterans may not know what care is available or their eligibility to access it.
 - Some ex-members do not identify as a ‘veteran’, which may impact whether and how they engage with DVA.
 - Some veterans may disengage with DVA because of their experience with the claims process. We discuss this in detail in Chapter 25, Entitlements and claims processing.⁸⁹
77. The Commonwealth disagreed that there is a lack of engagement among the veteran population with DVA support. Instead, it said the evidence only supported the idea that not all veterans are clients of, or interact with, DVA, and that ‘not all veterans who have separated from the ... ADF require assistance from DVA’.⁹⁰

78. It referenced initiatives to improve engagement with health supports among veterans, including during transition.⁹¹ We support the intent of these initiatives, some of which we have discussed in section 18.2.2 and in Chapter 23, Transition from military to civilian life.
79. DVA previously acknowledged, however, that it can do more to support ex-serving members who need more support. Ms Elizabeth Cosson AM CSC (Major General Retd), a former DVA secretary, told us:
- I think there is certainly more DVA could do in [the health] system to ensure veterans are accessing the support and services which they are eligible to receive. At the moment a lot of veterans and families are not aware of what supports and services they can receive.⁹²
80. It is important that the circumstances of these veterans and their families are better understood through research and engagement, and that more is done to understand barriers to accessing care.
81. We urge DVA to continue to focus on initiatives targeting veterans who may need its support but are not accessing it.

18.3.2 Civilian healthcare complexity presents new barriers to veterans

82. While serving, a member's health care is provided by Defence.⁹³ Once a member transitions, they must familiarise themselves with the Australian healthcare system. This includes Medicare, private health insurance, the hospital system (public and private) and health care offered through GPs, specialists and other providers.
83. This can be challenging. As Professor Bradley Murphy, Adjunct Professor at the University of Queensland and a former Navy Medical Officer, told us:
- veterans, when they're actually serving ... are hand fed their health care throughout their service ... When they're discharged from the military, then they're just let loose and so, you know, they don't necessarily understand what Medicare is and the likes.⁹⁴
84. Health literacy can help ex-serving members make informed decisions about their ongoing physical and mental health. Health literacy is 'how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it'.⁹⁵
85. Research has found that people with low health literacy are more likely to have worse overall health outcomes.⁹⁶ According to the Australian Medical Association (AMA) 'health literacy has a strong influence on individual health behaviours, as well as individuals' capacity to appropriately manage health conditions'.⁹⁷

86. Mr Adam Monkhouse, then Acting Director of Health Services Programs and lead for the veterans' health portfolio in South Australia's Department for Health and Wellbeing, told us that health literacy was a barrier affecting the provision of health care to veterans:

it's an unfamiliar health system. The health system is complex and requires a level of health literacy to be able to navigate it to understand the difference between public and private sectors, state government, federal government, what does my Medicare card do, what does it get me, what – do I need private health insurance. And that is something that veterans may be coming to, coming out of service, not having had to look into the private insurance market before or not having had a Medicare card before. Similarly, the transient nature of deployment and postings means that they may be in a capital city or in a regional area where they don't know the local services.⁹⁸

87. We also heard how poor health literacy can interact with stigma and other cultural barriers to help-seeking to create additional challenges in accessing health care.⁹⁹ We explore these in Chapter 15, Promoting health and wellbeing among ADF members, and Chapter 7, Culture and leadership.

88. Given its impact, health and health literacy must be a key focus during a member's transition. DVA has acknowledged the importance of this. It told us:

The way in which members make the transition from military to civilian life, and from the support provided under the Defence health system to the DVA compensation and rehabilitation system, can have a considerable impact on their long-term wellbeing.¹⁰⁰

89. Yet we have heard evidence of insufficient support to build health literacy during transition. Ms Kate-Frances Duffy, an ex-serving member, told us transition was:

hard to navigate as in what healthcare you need, how – because we're used to obviously having free medical, free dental in the military, which is amazing but, yeah, how to do those things for yourself that you normally don't have to do because ... you don't have the requirement to do it because you don't need it. I would have loved help with that, yeah.¹⁰¹

90. She continued, 'It was very much: find yourself a GP'.¹⁰²

91. Another ex-serving member relayed their concerns about the health information provided to members during transition:

Transition programs should also include ... education about Medicare and other civilian activities that personnel who joined at a very young age may never have developed skills or knowledge about.¹⁰³

92. This aligns with Defence material provided to the Royal Commission. We reviewed the health care and health insurance slides delivered at transition seminars in 2023 and attended a seminar. Just a small amount of time was spent on Australia's healthcare system and it only covered high-level information.¹⁰⁴
93. A lack of support to build health literacy during transition can have negative consequences. We were told this can make it difficult to engage with, and build relationships within, the health system, and can lead to distrust.¹⁰⁵ These can contribute to worse outcomes for a veteran's physical and mental health.
94. The Commonwealth told the Royal Commission that it 'acknowledges there is always more that can be done to increase understanding of the health system; however, this issue is not unique to the veteran community and could affect any demographic group in Australia'.¹⁰⁶ It noted that a range of initiatives aim to build health system literacy among veterans, including through the Veteran Support Officer program.¹⁰⁷
95. Given the importance of health literacy, and the shortcomings identified in the evidence before us, we believe that it is imperative Defence and DVA do more to support veterans to build health literacy as part of transition.
96. In Chapter 23, we recommend the Australian Government makes DVA responsible for supporting members to transition to civilian life. This should include helping members understand, access, navigate and connect with the Australian health system. Health should also be part of the cultural transition program that we propose in Recommendation 81 in Chapter 23.

18.3.3 Issues with continuity of care following transition

97. Continuity of care after transitioning from service is vital to ex-serving members' health care. We have heard some members received inadequate continuity of health care during their transition. It affected the level of care and support provided after their service.
98. Ms Siu Ping Wong, a former Air Force member, suffered an injury during training and was medically discharged from the ADF:

I was put in a position where I had to sign my medical discharge paperwork. This was not a good experience for me. I felt ill-informed, pressured to just sign, and there was no discussion about what my options were or what treatments I needed to regain my physical or emotional health. At that point I was so stressed that I was not eating.¹⁰⁸

99. The transition experience was detrimental to Ms Wong's ongoing health care:

After the medical discharge, many documents were not completed. There was no organisation of my post-discharge care (such as a referral to a GP or other health providers). I just had a discharge paper and told to sort out future care myself.¹⁰⁹

100. Ms Wong told us this experience contributed to ongoing health issues after she left service.¹¹⁰
101. The fact that some veterans experience poor continuity of care as they transition out of the ADF is not acceptable. As Ms Wong's case demonstrates, this can negatively impact veteran's health outcomes.
102. Continuity of care during transition is affected by the division of responsibility for health care for serving and ex-serving members. This can pose issues such as those discussed in section 18.3.6, including regarding the collection and sharing of data.
103. The Commonwealth disagrees there is a lack of continuity of care more generally. It told us about a range of programs and initiatives implemented by Defence and DVA (including through Open Arms) that aim to improve continuity of care.¹¹¹ In section 18.2.2, we outlined some of the initiatives that we recognise as important.
104. However, we think there is more to do, and there are limitations to some of these programs. For example, DVA told us it continues to work on the Early Engagement Model, but due to privacy concerns about data exchanged under the model, there is 'considerable scope' to provide more support.¹¹² Likewise, the Transition Medical Assistance Pilot Program (TMAPP) and the Enhanced Veteran Support Officers Pilot are time-limited trials, operating at a small number of locations.
105. Veterans raised concerns about whether programs supporting continuity of care will endure.
106. Ms Carleen Jones, a Navy Commander Aerospace Engineer, told us that the TMAPP provided 'essential services' to ADF members medically discharging at Duntroon.¹¹³ As described in section 18.2.2, TMAPP helps members separating on medical grounds so DVA can determine initial liability before separation.
107. Ms Jones described how TMAPP helped her through the hardship and distress of her injury to get the care and services she was eligible for. In her submission, she said:

Thankfully, I was placed in the TMAPP program, a trial DVA program run out of DHC [Duntroon Health Centre]. DVA staff went through my medical records, organised any necessary testing and reporting, and did essentially all the legwork to put together any appropriate DVA claims on my behalf. They got the lumbar spondylosis claim together for me, that I simply could not have. It was approved, and a process has now commenced to evaluate me for desperately needed home help. There is no way I could have achieved that without TMAPP. Additionally, these staff actually understood injury and the mental impacts. No one else in the medical centre seems to. They understand how triggering a discussion, or writing a statement can be. They understand trauma.

They understand brain fog, stress and mental health impacts. The regular staff of the medical centre don't seem to get that at all. It seems to be more like 'how's your back going – getting better?' and a sympathetic, but not particularly insightful response to me breaking down in floods of tears.¹¹⁴

108. Ms Jones expressed concern DVA was only operating the program as a trial and at a single location. She urged that it be extended and expanded:

The TMAPP program, as I understand it, is a trial which was made available only to a limited number of serving members who are most in need, and is only funded until June 2023. After that, its future is unknown. I strongly believe this program should be rolled out ADF wide. It certainly should not be cancelled. It is literally a lifesaver. Without help, ADF personnel in need, particularly those injured and leaving the ADF, have no way of getting the DVA claim support they desperately need, when they don't have capacity to get it for themselves.¹¹⁵

109. Defence and DVA must continue to take steps to enable continuity of care during a member's transition. There should be extra emphasis on supporting members with complex health needs, and who may require additional support.
110. Programs that provide ex-serving members better continuity of care deserve support. Where these have demonstrated positive results, they should be expanded so that more members and veterans can benefit from improved continuity of care.
111. DVA evaluated TMAPP in 2023 and established that the provision of medical evidence 'improve[d] the transition experience for participants'.¹¹⁶ It found that demand for the program exceeded supply and word of mouth was 'very positive'.¹¹⁷ Because of high demand, engagement with ex-service organisations (ESOs) and advocates was not undertaken.¹¹⁸
112. It proposed a 'scalable and sustainable model [of the program] ... be developed and considered by Defence and DVA'.¹¹⁹
113. In Chapter 23, we recommend that DVA take lead responsibility for supporting members to transition to civilian life (Recommendation 80). Efforts to provide better continuity of care should then include:
- augmenting and expanding existing DVA initiatives, including the early engagement model and pilot programs discussed in section 1.2.2
 - ensuring that relevant Defence processes, including notifying DVA of members who have been medically discharged and providing it with medical information, work appropriately
 - progressing and successfully implementing a data-sharing and analytics program as we discuss in section 18.3.6.

18.3.4 Barriers preventing access to health care

114. Once veterans have identified they need healthcare services and they are eligible for those provided through DVA, they face two major barriers.
115. First, they must access liability care through DVA's claims process, which we examine in Chapter 26, Supporting DVA claimants and clients, and Chapter 25, Entitlements and claims processing.
116. The second barrier comprises the constraints and disincentives faced by providers, which limit the supply of health care to veterans. We discuss these here.
117. Addressing supply constraints is critical. As discussed in Chapter 14, Introduction to health care for members and veterans, a lack of access to health care, including mental health care, is a risk factor for suicide.

Fee schedules

118. There is a strong body of evidence suggesting that DVA fees reduce veterans' access to health care. This is an issue that has been raised in multiple recent reviews (see Box 18.2) and is affirmed by our own analysis.
119. DVA arrangements are indexed each year in line with the Medicare Benefits Schedule, as well as allied health and dental schedules.¹²⁰
120. Generally, DVA fees are higher than those providers are paid through Medicare. GPs' services, for example, are paid at 115% of the listed Medicare Benefits Schedule, plus the relevant payments under the *Military Rehabilitation and Compensation Act 2004* (Cth) or the Veterans' Access Payment.¹²¹
121. Providers can access other loadings in certain circumstances. For example, the Rural Enhancement Initiative (REI) loading, available to GPs who provide certain services to veterans in rural public hospitals, is an additional 10% of the GP's fee.¹²²
122. However, as previous reviews have noted (see Box 18.2), this does not mean DVA fees are attractive or adequate for healthcare providers. There are several reasons for this.
123. First, indexation for Medicare and allied health fees was frozen from 2013 to 2018 (and only commenced after 2018 for some services), which also applied to DVA fees.¹²³ Using weighted averages across Australian capital cities, Australian Bureau of Statistics data shows that the Consumer Price Index increased by around 11% from 2013 to 2018, and health inflation by 24% over that period.¹²⁴ As a result, the real value of fees DVA pays has declined.
124. Second, unlike under Medicare arrangements and other schemes, healthcare providers cannot charge a gap fee or co-payment for DVA-funded services.¹²⁵ The DVA fee is the full payment they receive, so providers who do not bulk bill patients are better remunerated than they would be if they were seeing DVA patients.

125. Third, DVA fees are not competitive with those offered by other schemes, including workers compensation and the NDIS.
126. According to DVA, the current DVA payment (as at July 2024) for item 23 is \$47.65.¹²⁶ Item 23 covers a standard GP consultation of at least 6 minutes and less than 20 minutes.
127. We examined payments made by Victoria, Queensland and South Australia for item 23 under their respective workers compensation schemes. The current payments were \$73, \$102 and \$102, respectively.¹²⁷ (The New South Wales workers compensation scheme uses different item numbers, making a direct comparison more difficult.)
128. We also heard reports of disparities between the DVA fees schedule and rates available to people who receive funding through the NDIS.
129. Dr Bernadette Boss CSC, former Interim National Commissioner for Defence and Veteran Suicide Prevention, told us about the feedback she received on this subject:

I was told of that repeatedly. Everywhere I went, that was one of the issues that veterans faced. I was told that there is a rule that prevents veterans from topping up, so effectively veterans told me that they would go to a psychologist or a psychiatrist and their books would be full, but then other people on the NDIS could go and the books were open for them, and it was to do with the different rates that were paid. So veterans felt that they weren't getting access to services because the clinicians were not getting paid at a comparable rate to others – and NDIS was an example given to me on a number of occasions.¹²⁸

130. Dr Kieran McCarthy, an operator of the GO2 Health medical centre and a veteran, told us:

You join the Defence Force and DVA give you a White Card with mental health on it and you can go and see a psychologist if you need to, except you can't see a lot of psychologists because the general psychologist gets paid \$144 an hour and WorkCover pay \$188.40 an hour, and NDIS is even higher and privately it's even higher, and you are dealing with highly complex people and there's a lot of work involved, therefore a lot of psychologists won't see veterans and the paperwork around them.

Psychiatry is the same, specialists the same. It is not just psychology, it is also physiotherapy, exercise physiology or allied health. They are underpaid, the GPs are underpaid for the work they are required to do and I think that's the challenge moving forward.

It's the government, so I don't understand why DVA have a different fee structure to WorkCover, to NDIS. It should be the same.¹²⁹

131. An ex-serving member told us of their experience accessing physiotherapy:

I have a physiotherapist who treats a number of veterans, and he has advised me of the following:

- If he treats a veteran for one hour, he is paid \$120.00.
- If he treats a person through NDIS, he is paid \$200.00.¹³⁰

The impact of current fee arrangements

132. We have heard significant evidence that the DVA fee structure is affecting veterans' access to health care.

133. Professor McFarlane, for example, told us:

One of the problems that has happened with time is that those rebates have really fallen behind the levels of remuneration ... that would occur through third party compensation systems, or are charged by many better-quality specialists in Australia. So, often, veterans can't find specialists who will accept the DVA rates, and equally the networks of specialists with particular expertise, in areas like post-traumatic stress disorder, I think are much more difficult to navigate. So, essentially, DVA will pay for a veteran to see any medical practitioner or psychologist who accepts their rates, the problem is that often practitioners won't accept their rates.¹³¹

134. In a media release from July 2023, the Australian Physiotherapy Association stated:

Physiotherapists are struggling to keep up with the cost of DVA client sessions even though the demand for quality treatment is so high.

The DVA fee for physiotherapy services sits chronically low at \$67.95 and does not support veterans to access the care they need and deserve. Physiotherapists are not remunerated for extra time, assessment or diagnostic tests under the scheme, irrespective of the client's needs.

Ninety-one per cent of physiotherapists surveyed also stated that the current level of funding for physiotherapy does not enable them to sustain care for veterans. The market fee for general physiotherapy is approximately \$142.00, more than double the DVA fee. This results in up to a \$74.00 shortfall for practitioners for an initial consultation.¹³²

135. We received a submission from a rehabilitation consultant working with ex-serving members. It discussed the fee discrepancy in relation to psychiatrists:

It has come to my attention that it is generally very difficult for a veteran to secure an appointment with a psychiatrist. A large portion of psychiatrists refuse to treat patients under the DVA scheme, and this results in veterans experiencing difficulty accessing specialist and competent psychiatrist services ...

In my experience after researching psychiatrists in Sydney that specialise in post-traumatic stress disorder (PTSD) and contacting seven clinics, only two would accept a DVA client. For a community that may not have the adequate health literacy, this could lead to a veteran simply not accessing much required assistance.

In order to place our veterans in the best position to manage their mental health, a review of the schedule of fees for psychiatry and other health services is required to improve access to life saving treatment.¹³³

136. This evidence aligns with the experience of ex-serving members. Mr William McCann, an ex-serving member, told us:

My psychiatrist, however, was retiring at the end of 2018 and I needed to find a new one to continue my treatment post discharge. I called every psychiatrist in the Canberra region to get an appointment however I found the ones that had availability would not bill DVA and those that did had a 9- to 12-month waitlist.¹³⁴

137. DVA is aware of this issue. When discussing factors impacting veterans' ability to access psychiatric services, its Mental Health Expert Advisory Group agreed 'the fee parity is a major factor'. It said 'improving remuneration by increased fees has the potential to improve recruitment and retention and drive increased training demand'.¹³⁵

138. Importantly, the Commonwealth agreed that current fee arrangements affect healthcare providers.¹³⁶ It said:

Contemporary evidence from DVA stakeholders (e.g. representations to DVA and to ministers) in addition to quantitative analysis undertaken by Ernst and Young in 2019–20, suggests that DVA provider fees are uncompetitive and below market rates and likely contributing to access issues to healthcare providers for veterans, particularly in areas of workforce shortage.¹³⁷

139. It qualified this, however, by noting it is 'difficult ... to categorically determine the extent to which current DVA fee arrangements contribute to access issues to healthcare providers compared with other contributors such as workforce shortages'.¹³⁸ It noted the Veterans' Access Payment, and said that 'there are thousands of healthcare providers in Australia who continue to accept the DVA Veteran Card for full payment of their services despite current fee arrangements'.¹³⁹

Box 18.2 Previous findings on the DVA fee schedule

The DVA fee schedule has been identified as an issue of concern by several previous reviews.

Productivity Commission review

In its 2019 report, *A Better Way to Support Veterans*, the Productivity Commission said:

DVA's relatively low fees for some (but not all) health services, may mean that some veterans with service-related conditions have less accessible and lower quality services than people covered by civilian workers' compensation schemes.¹⁴⁰

The report recommended DVA commission an independent review of its fee-setting arrangements.¹⁴¹

Ernst & Young review

In 2019, following the release of the Productivity Commission's report, DVA commissioned Ernst & Young to review DVA fees. It found 'DVA fees [for GPs and medical specialists] have moved out of line with market rates as DVA uses the MBS [Medicare Benefits Schedule] as a reference rate'.¹⁴²

Interim National Commissioner's review

In the 2021 *Preliminary Interim Report*, the Interim National Commissioner said:

I have also heard of issues arising from the disparity between the DVA fee schedule and the fees that healthcare providers would otherwise charge clients – either through the private system or through other Australian Government schemes, such as the National Disability Insurance Scheme (NDIS). These issues may result in veterans being at a disadvantage when trying to find experienced and highly skilled clinicians who will treat them.¹⁴³

The report called for a revision to the DVA fee schedule for mental and other health care, to align with AMA fee lists and other schemes like the NDIS.¹⁴⁴

Existing initiatives

140. On 8 October 2020, the Australian Government delivered an interim response to the Productivity Commission's report, *A Better Way to Support Veterans*. It addressed 25 of the 69 recommendations and allocated \$94.3 million over 4 years 'for mental health, social worker and community nursing provider fee increases and simplification'.¹⁴⁵ The government committed a further \$175.3 million as part of the 2021–22 Budget 'to support the health and wellbeing of veterans and their families'.¹⁴⁶

141. In addition, DVA has:

contributed to work undertaken in the 2023–24 Budget to triple the Veteran Access Payment for GP services delivered to eligible Veteran Card holders. This measure is currently being implemented, in collaboration with the Department of Health and Aged Care, and will take effect from November 2023.¹⁴⁷

142. While this additional funding is positive, it does not address the underlying issue that DVA fees are still significantly out of step with other comparable schemes. The DVA Secretary has acknowledged more work is needed:

The government in the recent Budget announced a tripling of the Veteran Access Payment, which is a bulk billing incentive, essentially, that tripled in line with the bulk billing incentive that GPs receive for that billing practice ... So there was a very recent change in the Budget that would make a significant impact to the money received by general practitioners for provision of services to veterans. However, there are still – that concern continues. I won't suggest that that has dissipated that concern. It is the subject of ongoing work in the department.¹⁴⁸

Next steps

143. The DVA fee schedule cannot be considered in isolation.

144. Broader labour market issues affect the provision of health services. Australia's physical and mental health workforce is suffering worker shortages, which can affect access to care. This may be more acute in areas or regions where the market does not provide adequate health services. These issues will continue to affect access to health care, even if fee schedules are revised.

145. We acknowledge that DVA-funded health care is just one component of Australia's health ecosystem. There are other major sources of funding for health services, including Medicare, NDIS and aged care funding schemes. These all operate in the same market: they fund the same GPs, hospitals, and allied care and mental health support services.

146. As the Australian Government has acknowledged, changing the settings for one program can have unintended, flow-on impacts for others, with implications for the populations they serve.¹⁴⁹ We agree these impacts need to be considered, and that funding settings across health and support services should be well coordinated. We also note that government has begun to explore how different components of the care and support economy interact.¹⁵⁰

147. Nevertheless, it is not acceptable that DVA fees for health services remain consistently lower than those provided through other schemes. This is especially the case given that this issue has already been identified in several previous reviews.

148. In Recommendation 71, we urge the Australian Government to correct this by aligning the DVA fee schedule with those fees provided through other schemes. Failure to do so will continue to put veterans at a disadvantage in accessing the health care they need.

Delayed payments

149. There can be considerable delays in DVA transferring payments to healthcare providers.
150. Mr Barry Quinn, State President RSL Tasmania, told us ‘we are aware of cases where GPs do not wish to treat veterans because of having to deal with the bureaucracy of [DVA]’.¹⁵¹

151. Dr Megan Gilbert referenced payment delays for doctors in her submission:

I am not talking about the amount that doctors are paid, even though this is well below what a doctor could charge for services rendered but more in regards to actually paying them at all. For example, I currently I have 177 outstanding invoices which go back almost to the start of when I first commenced seeing veterans and probably amounts to more than \$70,000. This situation understandably leads to some clinicians refusing to treat veterans which means that these people may not be able to get the appropriate treatment when and from whom they need it.¹⁵²

152. Dr McCarthy and Mr Roderick Martin operate the GO2 Health medical centre, a privately owned primary and allied care clinic in Brisbane. Dr McCarthy told us:

As a clinic, we, I think, literally employ three admin staff to manage DVA invoices and chase DVA for payments. It’s a government organisation so this isn’t new. It’s a challenge for us because we are a very lean organisation financially. One of those issues is just chasing your tail, trying to get payments through ...¹⁵³

153. Mr Martin added:

We currently run at about between \$60,000 and \$70,000 outstanding in payments that go back two years ...¹⁵⁴

154. DVA told us the most common complaint it has received from healthcare providers in recent years is about ‘payment of accounts’, with 87 complaints received since 1 July 2019.¹⁵⁵ The small number of formal complaints may also mean they do not capture the actual number of providers affected.

155. Services Australia processes payments and is required to report to DVA against agreed service standards. While the service standards specify timeframes for processing payments, we learned the ‘reporting does not include information about the average time taken to provide payments to healthcare providers’.¹⁵⁶

156. The Commonwealth told us it ‘acknowledges delayed payments and the administrative burden of requests for information from DVA can affect healthcare providers’.¹⁵⁷ It noted that the ‘majority of claims for payment submitted by DVA healthcare providers are processed directly by Services Australia, without DVA involvement’.¹⁵⁸

157. It added that:

From at least 2020 onwards the Commonwealth has met service standards for processing. Unfortunately, more recently Services Australia has experienced challenges in meeting processing and telephony demand across the programs it administers due to the significant increase in work across their responsibilities. As a result, some healthcare provider payments have been delayed, particularly for manual claims.¹⁵⁹

158. It said that for manual claims, which make up around 271,000 claims (or 1.78%), service standards were not met.¹⁶⁰

159. We are also aware DVA is engaging more generally with health professionals, including through the Mental Health Expert Advisory Group and its General Practitioner Advisory Group. It is important that DVA uses these groups to maintain a focus on the timeliness of payments.

160. Recommendation 71 urges DVA to improve the time it takes to pay healthcare providers. The service standard should be expanded to include a timeframe to pay providers, which must be included in reports.

Administrative issues

161. Another disincentive for providers is the paperwork associated with seeing DVA clients, which is complicated and time consuming.

162. Dr Mary Frost has been a practising psychiatrist in the Northern Territory since 2001 and has extensive experience in seeing Defence members and veterans. She told us:

So DVA will only fund medical consultations with the ... veteran present in front of you, and yet DVA will send form after form ... to be filled ... which they are not prepared to fund unless the veteran is sitting there. Now, I just don't have the capacity to invite someone back every time they need a form filled. And so then over time, I do it pro bono, and then over time, like all, when you do an excess of pro bono work, you become resentful, and then over time you stop doing it and you just refuse. So I find that personally morally repugnant that I am no longer able to assist veterans because I can't afford to because my practice would go under.¹⁶¹

163. We asked DVA about feedback from its healthcare provider stakeholders. It informed us its Mental Health Expert Advisory Group provided feedback about the administrative burden:

[Mental Health Expert Advisory Group] members advised a major barrier in addition to consultation fees is the administrative burden for psychiatrists to prepare compensation reports, in particular the time required to complete reports ...

Members also discussed the questions contained in medical reports for DVA and said that these are often broadly worded making it difficult to provide the information DVA requires.¹⁶²

164. The Department's General Practitioner Advisory Group provided similar feedback:

GPAG [General Practitioner Advisory Group] members have noted filling out compensation forms is challenging for practitioners because the forms are time consuming and can be unclear where terminology is used inconsistently. This can lead to conflicting information resulting in rework/duplication of effort creating unnecessary delays in claims processing.¹⁶³

165. In June 2024, DVA told us that it had 'reduced the complexity of 203 medical forms and consolidated 73 forms into 29 forms to support reduced time taken to process claims'.¹⁶⁴ It is important that this work is communicated to health providers.

Shortages in the health workforce

166. Shortages in Australia's health workforce are well documented, and they compound barriers veterans face in accessing physical and mental health care.

167. The *National Mental Health Workforce Strategy 2022–2032* identified significant supply issues in Australia's mental health workforce:

there are significant shortages of all professions in the mental health workforce. These shortages are getting worse, and they have the potential to curtail the amount and quality of care provided across all settings. Too many people are waiting too long or missing out on vital mental health care, particularly people living in regional, rural and remote areas, and our disadvantaged populations, including First Nations people.¹⁶⁵

168. The Royal Australasian College of Physicians identified issues with medical and health practitioner availability, particularly in rural and remote areas.¹⁶⁶ This reflects broader issues with the distribution of the Australian health workforce: in 2023, there were more (registered, full-time equivalent) medical professionals in major cities than in all other areas of Australia combined.¹⁶⁷

169. The Australian Government recognises these broader challenges. Its *Draft National Strategy for the Care and Support Economy*, released in May 2023, discusses issues with Australia's care and support workforce, including workers that support veterans. The strategy:
- recognises that current workforce shortages are impacting care outcomes
 - explains the problem of 'thin markets', where certain populations or certain regions face inadequate provision of services
 - sets out steps to build out Australia's care and support workforce.¹⁶⁸
170. Similarly, DVA told us it 'agrees with the premise of the proposition to the extent that shortages in health workforce are impacting access to health care services for Veteran Card holders'.¹⁶⁹ It said this was an issue that affected the wider health system, and noted that the DVA 'treatment population' accounted for less than 2% of the Australian population.¹⁷⁰
171. We recognise that workforce issues impact health and wellbeing outcomes for all Australians, not just veterans. As the *Draft National Strategy for the Care and Support Economy* acknowledges, this poses a significant policy challenge for government, and may require long-term initiatives to address.
172. Nevertheless, workforce issues must be an area of focus if barriers to accessing veterans' health care are to be removed. We urge the Australian Government to continue to focus on this area. It should investigate and progress initiatives proposed in the *Draft National Strategy for the Care and Support Economy*, as well as those that affect other aspects of health care delivery. It should also consider offering incentives to build the health workforce; for example, by supporting training and mentorship opportunities.
173. As outlined in Recommendation 71, the Australian Government should consider how fee arrangements can mitigate supply issues regarding the healthcare workforce, including in thin markets.

Recommendation 71: Increase the Department of Veterans' Affairs fee schedule so it is aligned with that of the National Disability Insurance Scheme

The Australian Government should amend the Department of Veterans' Affairs (DVA) fee schedule to mitigate the challenges faced by veterans in accessing health care, ensuring that:

- (a) at a minimum, the revised fee schedule aligns with that of the National Disability Insurance Scheme
- (b) efforts to mitigate supply constraints are prioritised, such as non-fee-for-service components, additional loading, and/or incentive payments, including in areas with few health services for the populations being served.

DVA should reduce the time taken to pay healthcare providers, and track and publicly report on the time taken to provide these payments.

18.3.5 Shortcomings in understanding and meeting the health needs of veterans

174. Veterans' health needs differ from those of the general population. They are more likely to experience particular health conditions. The impact of the physical, mental and social stressors of service may shape their long-term health profile. Their military experience can also affect how they interact with the health system and healthcare staff.

175. Sometimes, veterans will present as highly complex patients.¹⁷¹ Some may have 'chronic and more enduring conditions'.¹⁷²

176. Dr McCarthy told us a better understanding of members' needs can support better health outcomes:

these are different people, they are not the average punter on the street, you have got to talk to them a certain way, you have to understand their background, they are a bit needy, a bit entitled, but it is very important that we get the right people talking to them so we can get the right outcomes as fast as possible.¹⁷³

177. This Royal Commission heard this is not what veterans experience in practice. Some have told us how a lack of cultural competency is impacting their health care. In one submission a veteran said:

One of the major barriers within the current system is the experience and suitability of general practitioners within the wider community to provide quality health care to veterans – a fundamental problem impacting far too many veterans ... [T]he overwhelming number of GPs within the community have no experience or exposure to the military environment or culture, so their ability to provide the quality of health care required by veterans is compromised from the outset.¹⁷⁴

178. Without an understanding of military culture and the experiences of ex-serving members, health practitioners will not be able to provide appropriate and effective treatment and services. This can be achieved through:

- augmenting specialised health care for veterans
- building veteran cultural competency among mainstream health services.

Veteran cultural competency among mainstream health providers

179. Mainstream health providers will continue to serve the majority of veterans. This means cultural competency relating to veterans must improve among these services, so they can deliver appropriate health care.

180. Cultural competency means understanding the cultural factors that can affect health and healthcare.¹⁷⁵ We discuss this in more detail in Chapter 14, Introduction to health care for members and veterans.

181. A number of initiatives seek to build veteran cultural competency among health workers in Australia:

- DVA offers training modules to help health workers provide care for veterans, including accredited modules health professionals can use for their continuing professional development (CPD).¹⁷⁶
- DVA is developing a tailored Primary Health Care Training Program to enable ‘improved quality of care and claims submission for veterans’.¹⁷⁷ This is designed primarily for GPs, although ‘some of the training modules will be of interest/ relevance to other interested health professionals’.¹⁷⁸
- Royal Australian College of General Practitioners (RACGP) offers several programs for GPs. ‘Military and Veteran Health’ is a CPD unit for members.¹⁷⁹ RACGP CHECK is an online training module focused on ex-serving members’ health, which covers ‘both clinical treatments and DVA administrative detail’.¹⁸⁰
- DVA funds the Military and Veteran Psychiatry Training Program, through which the Royal Australian and New Zealand College of Psychiatrists (RANZCP) provides registrar training positions to build the number of psychiatrists with interest and expertise in veteran and military health.¹⁸¹

182. Some of these initiatives are very recent, making it difficult to assess their impact. RACGP CHECK, for example, was released on 22 March 2023. By 3 January 2024, a total of 1,308 (around 3%) of Australia’s GPs had completed the training.¹⁸²

183. In their joint submission, Suicide Prevention Australia, Mental Health Australia and Relationships Australia called for veteran cultural competency training to be expanded. They said:

There have been trials and limited programs to increase ‘veteran cultural competence’ with some professional groups, including GPs, psychiatrists, and other mental health professionals. However, participants at our roundtable discussions emphasised the importance of this training across a much broader group of services supporting veterans and their families, including crisis response workers and social services.¹⁸³

184. We welcome initiatives by DVA to promote veteran cultural competency among health workers. These should continue, and DVA should continue to promote this work, including through partnerships with professional bodies.
185. DVA should expand its efforts, including to new segments of the health and support workforce where a need to do so has been identified. This could involve making existing training initiatives available to other interested health professionals. The measures that we propose to support the establishment of a Research Translation Centre for Defence and veteran health care can also be leveraged to help with this. For details see Recommendation 62 in Chapter 14.

Specialised care for veterans

186. Australia is home to a variety of facilities and services that provide specialised care to veterans (see section 18.2.3). We use the term ‘specialised care’ to describe any health service which has been developed specifically for veterans.

The role for specialised veteran care

187. Specialised care can take a variety of forms. There are secondary and tertiary services located in hospitals, like those described in Box 18.1, that have evolved out of the former repatriation hospitals. There are also privately operated primary and allied care providers, such as GO2 Health. Some providers of mental health services also specialise in treating veterans.
188. Experts told us of the important role specialised care can play in meeting veterans’ health needs. Professor McFarlane noted how veterans’ health can involve a wide spectrum. He told us specialised care benefits those with higher needs: veterans with ‘chronic and severe disorders who are the highest risk group’ and require ‘well-structured specialist treatment teams’.¹⁸⁴
189. SA Health’s Mr Monkhouse emphasised the diversity of the veteran cohort, noting how this shaped its range of healthcare needs:

You have a diversity of deployment experiences from peacekeeping to active combat operations and all of those things create, you know there’s no one-size-fits-all to providing the health services or meeting those health needs.¹⁸⁵

190. Dr McCarthy told us how specialised care in the primary care sector can build trust, thanks to a shared understanding of service. He said this can help veterans engage with health services:

the first step for us in this particular cohort, and this is my cohort, this is the world I came from, is trust. If we don't have trust, then it's very difficult often to engage with the ex-military people. So we try and start with that. In many ways the business started because I came on board and I was an ex-Army doctor and I have got some runs on the board, so people started seeing me.¹⁸⁶

191. Mr Monkhouse said there was a role for specialised services in meeting these needs within the larger health system:

So there is certainly very specific health services, like the Jamie Larcombe Centre and very specific mental health services that we provide as an almost a centre of excellence, a clinical excellence or a building of those skills that are tailored towards meeting those specific health needs ...¹⁸⁷

192. Mr Robert Fitzgerald was an author of the Productivity Commission's *A Better Way to Support Veterans* report focused on mental health services. He told us veteran-specific services could help 'fill the gaps' in the services offered through the mainstream health system, particularly in mental health care:

What are the gaps that need to be serviced by veteran specific services? ... I have absolutely no doubt that there is a need for veteran specific mental health services, either a standalone or as part of integrated other service systems. I think ... there will be a need for some mental health services specifically for the veteran community. We haven't detailed those in any great detail, but I think that would be the case. So the long and short from my point of view ... there may be gaps in the mainstream health system, and there certainly will be gaps and needs in the mental health system that should be specifically designed for veterans.¹⁸⁸

Views on specialised veteran care

193. Dr Boss's *Preliminary Interim Report* noted specialised services are generally well regarded in the veteran community:

Today ... certain state-led facilities, such as the Concord Repatriation General Hospital and the Jamie Larcombe Centre, which both provide medical services – including mental health supports – to the veteran community ... [A]ll reports from my discussions with state and territory government officials and individuals with lived experience indicate a very high level of satisfaction with them.¹⁸⁹

194. Ex-serving members told us of their positive experiences with veteran-specific services.

195. Ms Melissa McLean, an ex-serving Navy member, told us:

The most positive thing that has happened since I left was commencing a program at the National Centre Veterans Healthcare (Concord Hospital NSW), I have multiple doctors and healthcare professionals helping me get back on track which includes two different psychologists and a psychiatrist ... The National Centre Veterans Healthcare is the best thing out there to help veterans.¹⁹⁰

196. Another told us about their experience at the Jamie Larcombe Centre in Adelaide:

The experience I had there was very positive and since then I've been on the path to recovery but unable to work. I've been hospitalised there on four occasions since but each time I learn new things, connect with other veterans and receive cutting edge treatment from excellent staff. I realise there will be times in my life when I will need to go there and just having that support is excellent especially when you compare it to my early years post discharge.¹⁹¹

197. Other veterans told us the care they received at specialised facilities helped prevent their suicide.¹⁹²

Barriers to specialised care

198. Our inquiry found two major barriers to specialised care for veterans.

199. The first is access. Specialised tertiary facilities for veterans, like those described at Box 18.1, represent a very small component of the Australian healthcare system. It can be difficult to gain admission to them, even for those living in the few jurisdictions where they exist. As Professor McFarlane told us:

I know that particularly with the Jamie Larcombe Centre because ... in South Australia, there's another network of private practitioners who are constantly highlighting the difficulties of veterans accessing the Jamie Larcombe Centre.¹⁹³

200. As one veteran told us, they were only able to obtain a referral to a veteran-specific health centre on their ninth appointment with a GP.¹⁹⁴

201. Specialised tertiary facilities are clustered in locations that do not necessarily correlate with areas with large veteran populations. Depending on where they live, a veteran may face difficulties with the cost and practicalities of travel to access the care they need.¹⁹⁵

202. Issues around access also affect veteran-focused primary care. We heard from private providers who identified areas of unmet need for these services, but who face difficulty extending their service without additional support from government.¹⁹⁶

203. The second barrier relates to poor integration among and between veteran-specific services and mainstream health services.

204. Integration can affect the reach and impact of existing services. For example, it can help services to work together, share expertise and create systems of care to support individual patients.

205. Ms Linda Dawson is Deputy Director-General of Industry, Science and Innovation within the Department of Jobs, Tourism, Science and Innovation in the Western Australian Government. She told us of the challenges of effectively integrating services specifically for veterans, noting that:

it does require additional funding and it does require localised ... activation so that it connects into the existing services and does that in a really effective and complementary way. And if they don't work together they can actually cause fracturing and actually not achieve what they are intended to achieve.¹⁹⁷

206. However, we heard fragmented systems limit the impact of existing specialised care. Professor McFarlane told us:

I think the first issue about those centres is, in isolation, they look like important resources and there is some very good work done by those particular centres. However, they're not part of a system of care and I think the way in which they also are related to the other service providers in their regions is an area where there are many problems.¹⁹⁸

207. Dr Jonathan Lane is a serving member and Senior Lecturer in Psychiatry at the University of Tasmania. He was appointed Senior Psychiatrist at Open Arms in 2023.

208. In 2022, Dr Lane told us that integration with mainstream health services is particularly difficult in regional areas, where 'there are so many silos and there are so many gaps that people fall through because we don't have the connections, let alone the clinicians with the expertise to be able to coordinate through services'.¹⁹⁹

209. Together, these barriers contribute to what we believe is a patchwork system of specialised care.

210. DVA told us that it 'has a range of programs and other supports available to veterans to support access to healthcare, including specialised healthcare'. It noted the role of telehealth in improving 'access to specialised health services' that 'can now provide services over a larger geographic area'. The Commonwealth acknowledged that 'accessing suitable healthcare can be difficult in some locations, particularly for those living in rural and regional areas', but said this was the case across the broader health system, and was not 'confined to the veteran community'.²⁰⁰

Building networks of care for veterans

211. Veterans should have access to health care that meets their needs. A cornerstone of this is developing a health system that understands and responds to the unique needs of veterans in a comprehensive manner. This should be the foundation of governments' approach to specialised care for veterans.

212. Governments need to focus on two issues to enable this.
213. First, the coverage of specialised facilities and health services for veterans needs to significantly improve at the primary, secondary and tertiary levels.
214. However, not all health care for veterans needs to be delivered by veteran-specific specialists. Many veterans will continue to elect to receive the bulk of their care from their local providers, whether that be primary care practitioners or consultant practitioners such as their regular psychiatrist or psychologist, or their local mental health service. But on occasion, when required and in conjunction with their local providers, they may seek to receive care from a veteran-specific specialist service for a time-limited period.
215. Given this, it is imperative that providers and funders of health care work together regardless of sector, jurisdiction or specialisation, with the aim of developing a model that prioritises and delivers coordinated care to meet the health needs of veterans.
216. We believe these two approaches are complementary. Together, they should enable the development of regional 'networks' of care. Over the longer term, these should form a national network that provides health care to veterans regardless of where they live and corresponding to their level of need.

Improving the coverage of specialised care

217. The first priority for governments should be to increase the coverage of specialised care. They should address the barriers that veterans face in accessing specialised services, and enable a range of well-located, accessible services for those requiring this level of expertise.
218. We recognise this will be a complex undertaking. Achieving it will take time and a sustained commitment.
219. Improving the coverage of specialised care should involve:
- providing further support for primary and allied care providers in offering specialised services for veterans, to increase their number and expand their reach. This could be done through capital grants, or agreements to purchase their services, in addition to measures to enhance incentives and reduce disincentives (discussed in section 18.3.4). The aim should be to incentivise the provision of 'veteran-friendly' primary health care. This could be accompanied by efforts to promote these services to veterans
 - expanding secondary and tertiary health services for veterans. This could build on the model employed by the National Centre for Veterans' Healthcare in New South Wales and the Jamie Larcombe Centre in South Australia. Both are publicly administered facilities that provide a range of specialised services. Governments should consider establishing similar facilities in states that do not currently have them, especially in areas with large veteran populations that currently have

limited access to specialised services. Consideration should also be given to increasing the capacity of, or services offered by, existing facilities where there is a demonstrated need. Alternatively, governments could explore options within the private health sector to meet this need

- creating additional partnership agreements between DVA and primary health networks, particularly for those that serve large veteran populations.

Connected and integrated services

220. To be effective, specialised services must be integrated into the broader health system.

221. Integration must first occur at a local level. Doing so will help build awareness of the services available to veterans, support the development of better cultural competency, and improve veterans' experiences with better-coordinated health services.

222. Government should support better local integration by:

- improving awareness of specialised services for veterans, including through information campaigns
- promoting links between primary care providers, Open Arms, Veterans' and Families' Hubs specialised services and other healthcare providers within a local area; PHNs could play a role in building these links
- considering other ways to promote local exchanges to tighten relationships between medical and healthcare practitioners, including through training, mentoring and networking opportunities.

223. 'Black spots', where links to and awareness of specialised services for veterans are underdeveloped, should be targeted. This should include regional areas and jurisdictions with limited services.

224. Integration must also be national. This will enable information sharing and the 'spillover' of knowledge, which can support efforts to translate health research, improvements to clinical practice, and the development of knowledge around specialised care. Translating health research involves applying Defence and veteran health research findings to healthcare practice – including through education and training – to benefit ex-serving members and the healthcare system.

225. Government should support better integration at a national level by:

- setting up meetings or forums for those providing health care to veterans (for example, through the establishment of a Community of Practice)
- supporting links between large health providers, including state and territory health services and private facilities

- supporting the establishment of a research translation centre for Defence and veteran health that has established links to leading healthcare providers, as proposed at Recommendation 62 in Chapter 14, Introduction to health care for members and veterans
- supporting the ‘mainstreaming’ of DVA-funded services as far as possible, potentially including a Veterans General Practice incentive within MyMedicare (a voluntary patient registration model), and bringing DVA payments under the Services Australia accountability framework
- promoting national-level research and data initiatives such as the National Veterans’ Data Asset (at Recommendation 107 in Chapter 29, Use of data and research by Defence and DVA).

A priority for governments

226. In Chapter 24, Empowering veterans to thrive, we recommend the Australian and state and territory governments jointly develop a new National Funding Agreement on Veterans’ Wellbeing (Recommendation 88). This should be coordinated through the Veterans’ Ministerial Council.
227. The funding agreement would include several priorities, including increasing access to specialised care and integrating services into better networks.
228. Australia’s healthcare system is complex. It involves a range of actors – public, private, and not-for-profit – with all governments playing a role in funding or delivery. Because of this, it is appropriate all governments contribute to the development of better networks of care for veterans.
229. We acknowledge this will require sustained effort. Developing care networks will take time, and will require investment and the development of capacity and relationships.
230. As a first step, governments should undertake a comprehensive assessment of veterans’ health needs. This should include using data to identify where veterans live; their demand for, and access to, health care; and where they may be underserved by existing specialised or mainstream health services.
231. Where unmet need is identified, governments should consider how to better serve these needs through the expansion of specialised care, and by facilitating better coordination of services. The role of digital technology should be embraced in developing options for enhanced care and integration.
232. This could be achieved by the Australian and state and territory governments jointly funding an expansion of specialised secondary or tertiary care. It could also involve market testing; for example, to inform how an expansion of privately operated primary or allied care services could take place.

233. This work requires the input of stakeholders, including representatives from:

- state and territory government health systems
- private providers, including those servicing ADF members
- the not-for-profit sector
- primary health networks
- community groups, including ex-service organisations.

Recommendation 72: Expand and strengthen healthcare services for veterans

The Australian Government and state and territory governments should prioritise networks of care in the National Funding Agreement on Veterans' Wellbeing (Recommendation 88).

To enable this, the Department of Veterans' Affairs (DVA) should develop a plan to expand and strengthen specialised health care for veterans. It should set out how to bring together the different components of the health system to meet the health needs of veterans. DVA should complete the plan by September 2026 and submit it to the Veterans' Ministerial Council for endorsement as part of the funding agreement.

The plan must set out measures to improve the coverage of specialised veterans' care, including by:

- (a) providing support for primary and allied care providers whose services focus on veterans' health needs
- (b) expanding veteran-specific secondary and tertiary health services
- (c) developing additional partnership agreements between DVA and primary health networks.

It must also support the integration of veterans' health services at a local and national level, including by:

- (d) better informing veterans about available services
- (e) using existing health infrastructure, such as primary health networks
- (f) developing local exchanges to tighten relationships between medical and allied health care practitioners.

The plan should be guided by current and future needs and informed by data on Australia's veteran population showing the size of veteran communities in different areas, where specialised services currently exist or are lacking, and how and where veterans access health services.

Recommendation 73: Improve military cultural competency in health professions working with veterans

The Department of Veterans' Affairs (DVA) should complement the work outlined in Recommendation 72 by expanding its efforts to build cultural competency relating to veterans among health workers who operate in mainstream health settings. DVA should expand its training modules and enable health professionals working with veterans to complete them. It should promote this work, including through partnerships with professional bodies.

18.3.6 Other considerations affecting health care for ex-serving members

234. Other factors affect health care for ex-serving members. We discuss these in this section, and in detail in other chapters of the final report.

Oversight of outcomes

235. Previous reports have noted that DVA-funded healthcare services would benefit from a better understanding of veterans' health outcomes.
236. The Productivity Commission's 2019 report, *A Better Way to Support Veterans*, argued liability health care for veterans functioned as 'a "set and forget" arrangement for DVA'.²⁰¹ It stated:

Changes also need to be made to the way treatments and supports are commissioned and provided to veterans and their families. There needs to be more proactive engagement with ... health and mental healthcare providers (including requiring an evidence-based approach to treatment and supports) and better oversight of outcomes from treatment and support.²⁰²

237. The Productivity Commission proposed a 'data-driven and evidence-based approach to healthcare'.²⁰³ This would involve collecting data on utilisation (including services and costs) and outcomes, which would allow for better evaluation of specific health services and treatments that receive public funding.²⁰⁴
238. The Commission commended the Coordinated Veterans' Care Program as a positive step in this direction, although it found the program could 'be improved by better targeting and measuring of outcomes'.²⁰⁵
239. DVA's *2023–24 Corporate Plan* states 'wellbeing outcomes for veterans and families are considered in policy, service design and delivery, now and into the future'.²⁰⁶

240. It recognises health as part of a broader ‘wellbeing’ framework, where it is one of ‘eight interconnected domains’ affecting wellbeing outcomes for veterans and families.²⁰⁷
241. It cites initiatives like the Multi-Agency Data Integration Project (MADIP), which aims to ‘provide insights on socioeconomic issues, answer policy questions and evaluate the success of programs’.²⁰⁸ It is also designed to ‘support wellbeing measurement, and DVA’s journey towards becoming a wellbeing-driven organisation’.²⁰⁹ MADIP has since become the Person-Level Integrated Data Asset (PLIDA).²¹⁰
242. However, the plan says little about how these efforts come together to inform an outcomes-based approach to the commissioning and provision of health care, at least at any discernible scale.
243. DVA told this Royal Commission it ‘has been on a wellbeing journey since 2016’.²¹¹
244. It cited initiatives it had implemented to support better measurement of members’ health and wellbeing outcomes. They include the development of the Wellbeing Outcome Measure Tool, its client satisfaction survey, the data-sharing and analytics solution program, research undertaken by the AIHW, and the Data Integration Project.²¹²
245. DVA told us it has longer-term plans to build its understanding of wellbeing outcomes, to better inform decision-making:

Over the longer term, depending on available resourcing, the DVA MADIP research team also intends to develop supporting analytical capabilities. This includes, for example, the capability to undertake cost-benefit analyses and scenario testing to better inform wellbeing outcomes for veterans and their families.²¹³

246. It noted its data limitations, including the data’s ability to capture factors and life events, like employment and social support, that may impact wellbeing outcomes.²¹⁴
247. We recognise there are challenges associated with achieving particular health outcomes. The current approach to funding and delivering services provides significant flexibility. Veterans with a health card can choose from a marketplace of accredited providers. Even though there are shortfalls in the market, and some veterans may need help to access care, choice is critical in enabling autonomy.
248. However, DVA can do more to embed a focus on outcomes across the healthcare programs it funds and manages. It could do this by:
- improving the collection and use of data, including establishing the National Veterans’ Data Asset that we propose at Recommendation 107 in Chapter 29. This will enable better monitoring of how DVA-funded health services improve veterans’ health and wellbeing outcomes
 - developing partnerships with state and territory health services and other healthcare providers, like those described at section 18.3.5

- expanding case management programs, like the Coordinated Veterans' Care Program, to a wider cohort
 - ensuring future programs are informed by a clear understanding of the health issues they target and the specific outcomes they seek to achieve.
249. In Chapter 14, we note the importance of building expertise within DVA, including clinical expertise. This is important in helping DVA to develop better insight into veterans' health outcomes, and to inform its understanding of healthcare priorities.
250. The Productivity Commission also raised concerns around DVA's lack of understanding of the outcomes of its rehabilitation services, which is discussed in Chapter 26, Supporting DVA claimants and clients.

Consultation on health programs

251. Veterans' healthcare programs must be informed by robust consultation with the veteran community. Consultation leads to better outcomes and greater acceptance of a policy or program.²¹⁵ We discuss how DVA engages with the veteran community generally, including through the National Consultation Framework and its forums and working groups, in Chapter 24, Empowering veterans to thrive.
252. Here we touch on some health-specific issues and examples, as some DVA healthcare programs appear to be developed without adequate consultation.
253. In Chapter 22, Mefloquine and tafenoquine, we describe how DVA undertook extensive consultation on the Neurocognitive Health Program (later the Mending Military Minds program), only for the program to be discontinued.
254. Dr Jane Quinn, Professor in Veterinary Physiology at Charles Sturt University, was a member of the steering committee that provided extensive consultation in the development of the program. She told us:

The [Neurocognitive Health Program] ... underwent a 3.5-year process of co-design and co-development with the core steering committee, veterans with lived experience, their families, advocates, health professionals and members of [Open Arms].²¹⁶

255. She told us how the program was ended abruptly, without consultation:

No further meetings were arranged and the steering committee received an email ... that the program had now been concluded ... This was a complete surprise to the entire steering committee, with whom there had been no consultation related to this conclusion ...²¹⁷

256. Mending Military Minds was replaced by a GP-based program, which experienced low participation rates that declined further over time.²¹⁸

257. The example of the Veterans' and Families' Hubs is also very concerning. The decision to establish the hubs was announced by government, without DVA undertaking analysis, or providing studies, research or data, to inform where the six initial Veteran Wellbeing Centres would be located.²¹⁹ DVA said it was 'not aware of any consultation' that preceded this decision.²²⁰ We discuss the hubs in Chapter 24.
258. DVA has expanded the suite of health programs and services that it administers in recent years (see section 18.2.2). Consultation is important in shaping these programs, and maximising how they improve veterans' health.
259. DVA must meaningfully consult with the veteran community and employ tools that can enable this. Its organisation-wide Lived Experience Framework, which was developed in 2023 to support co-design and consultation, should guide consultation on its health programs.²²¹

The role for families

260. Families have an important role in supporting the health of ex-serving members.
261. Chapter 27, Importance of families, discusses how families can support sustainable and strong relationships that are important to an individual's mental health and wellbeing.²²²
262. It also outlines how families can support ex-serving members to seek help, access medical treatment and care, and continue to engage with the healthcare system. They do so by:
- identifying suicidality and mental health concerns²²³
 - helping with an accurate diagnosis²²⁴
 - supporting effective treatment planning and monitoring²²⁵
 - providing practical help, including help attending medical appointments and reminders to take medication²²⁶
 - maintaining engagement with health professionals²²⁷
 - fostering a sense of responsibility, duty and a reason for living.²²⁸
263. See Chapter 27, Importance of families, for our recommendations on supporting families in this critical role.

Data

264. The key to guiding the delivery of veterans' health care is information from data and other sources. DVA uses data to assess claims for non-liability health care. Data also supports clinical staff to deliver appropriate treatment and enable continuity of care.

265. Data provision is not helped by the fact Defence delivers health care for serving members while DVA funds care for ex-serving members.²²⁹ Both function independently of each other and operate their own systems and processes.
266. As a result, each department collects and retains its own data on members. Despite some data being shared across agencies, this division has implications for how it is used to support the health of veterans.
267. DVA claims staff have direct, self-service access to some member data through the PMKeyS – the integrated human resource management system for Defence personnel. They can also access the Defence work health and safety incident database linked to MyService, DVA's service portal for veterans.²³⁰
268. As part of the Defence and DVA Electronic Information Exchange program (now the Veteran Electronic Information Exchange), DVA staff have real-time access to certain information, including medical files, when it is required.²³¹
269. Previous analysis has highlighted issues with data sharing and information provision. This includes 'limited information received [by DVA] about a veteran when they are assigned to a new delegate'.²³²
270. We have heard that delegates need to request information such as service information, HR information and other medical information directly through Defence's single access mechanism (SAM) teams.²³³ This means they need to spend time 'gathering' (or chasing) information directly from Defence, which prolongs the claims process.²³⁴
271. Barriers to data and information sharing could exacerbate problems we raise in Chapter 16, ADF healthcare services, and Chapter 25, Entitlements and claims processing. For example, they could contribute to:
- delays in claims processing, which can prevent members from accessing timely health care and negatively affect their wellbeing
 - a lack of continuity of care during and following a member's transition
 - reduced incentives for members to report injuries and other health conditions during their service.
272. Since 2020, Defence and DVA have been developing a data sharing and analytics solution. This is a platform that brings both datasets together with analytics capability to provide a comprehensive and linked person-centric view of current and former ADF members and their families.²³⁵
273. While we commend this concept, we have identified issues with the scope, implementation and execution of the data sharing and analytics solution that could limit its utility. These are set out in Chapter 29, Use of data and research by Defence and DVA.

274. We understand both agencies are trying to improve information sharing while the rollout of the data sharing and analytics solution continues.²³⁶ We urge Defence and DVA to maintain focus on data sharing, and proactively address the issues with the data-sharing and analytics solution that we have raised.
275. Defence and DVA's objective must be the provision of comprehensive, timely and accurate information that underpins a veteran's access to health care that responds to their needs.

Privacy

276. We have been told privacy provisions and restrictions around data and information sharing can impact veterans' health care.
277. DVA told us that its ability to provide 'high-quality services and support to veterans and their families' is reliant on 'timely and appropriate access to data and the capacity to understand and utilise data'.²³⁷
278. However, it noted the impact of 'obstacles to more effective information sharing'.²³⁸ It said that the 'current legal frameworks can be inhibiting', as they affect DVA's ability to use personalised data without the consent of individuals.²³⁹
279. DVA argued that legislative reform should be considered to address 'barriers' to its collection and use of personal information:

Legislative amendments could be developed to confirm legal authority for the handling of personal and sensitive information under the Privacy Act. Other legislative considerations exist through the reform of veteran-related legislation and *Defence Act 1903 (Defence Act)* reform.²⁴⁰

280. It said that legislative reform would help facilitate early intervention and support wellbeing outcomes.²⁴¹
281. We note that the Veterans' Entitlements, Treatment and Support (Simplification and Reform) Bill 2024 (VETS Bill) appears to be a step in that direction. The Explanatory Memorandum for the Bill discusses changes meant to 'consolidate, standardise and simplify the authority for information exchange' to support the determination of veteran entitlements. This may streamline information sharing processes for ex-serving members, as they relate to claims.
282. We have discussed the impact of information sharing in other parts of this report, including in relation to its impact on families. In Chapter 16, section 16.4.3, we raise how, in 2021, Defence Families of Australia told us that Defence and DVA must do more to engage with families. It raised the impact of legislation but told us that the Privacy Act had previously been 'part hurdle, part excuse' for a lack of communication.²⁴²

283. Information sharing with families was raised in our *Interim Report*. Its Recommendation 12 was that, by March 2023, the Australian Government should increase the number of opportunities for serving or ex-serving ADF members to provide or amend their consent to disclose information to family members or nominated representatives.²⁴³ The government committed to a ‘pro-active approach to consent for access to information’ and said DVA and Defence had identified ‘immediate opportunities to provide or amend consent’.²⁴⁴
284. In Chapter 16, we explore privacy and information issues related to Defence. We recommend that Defence review its privacy policy and amend it as needed, including to provide clarity on consent and the situations in which a member’s health information can be shared (Recommendation 68). This includes when disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of an individual, or to public health or safety.
285. Recommendation 68 also calls on Defence to:
- help members understand consent and the Privacy Act
 - evaluate members’ understanding of consent and how Defence will use their personal information.
- We consider these to be important principles that should also apply to DVA. They should be prioritised, regardless of whether legislative reform is pursued.
286. Ultimately, Australia’s privacy framework should serve the best interests of veterans, including by supporting their health and health care. We recognise it is important that data and information can be used to enable appropriate and person-centred care for veterans.
287. If barriers in the legislation are negatively impacting the optimisation of the health care of veterans, then we agree that consideration should be given to whether the legislation should be amended.
288. With this in mind, we recommend that DVA seeks advice to clarify the boundaries of existing data and information-sharing provisions (Recommendation 74). This process should identify what changes to legislation, if any, are needed to enable timely and appropriate data and information sharing to support better outcomes for veterans.
289. The advice should clearly articulate what specific ‘barriers’ in the legislation pose issues for data and information sharing, and their impact on the support that DVA provides veterans, including in relation to their health outcomes. If DVA pursues legislative amendments on this basis, it must clearly explain how each amendment will support better outcomes for veterans.
290. Recommendation 68 in Chapter 16 also advises Defence to review and amend its privacy policy. If legislative barriers remain which affect the health, wellbeing or safety of serving members, then consideration should be given to extending the scope of legislative change to encompass serving members.

291. In the interim, DVA must ensure strict compliance with existing privacy protocols. In Chapter 29, we discuss a privacy breach affecting the Veterans' Medicines Advice and Therapeutics Education Services (MATES) program, a DVA-supported research program designed to improve the use of medicines and reduce adverse events. In light of this, we emphasise the continued importance of applying best-practice data-sharing practices and safeguards.

Recommendation 74: Clarify the application of the Privacy Act to veterans to determine whether amendments are necessary

The Department of Veterans' Affairs (DVA) should seek legal advice clarifying the application of the *Privacy Act 1988* (Cth) (and any other relevant legislation) to veterans and their families in the context of sharing data and information related to health, wellbeing and safety.

DVA should use this advice to inform consideration of whether legislative amendments are required to optimise the management of the health and wellbeing of veterans. Consideration may be given to extending the scope of any changes to encompass serving members, if this is needed following the review of the Defence privacy policy proposed at Recommendation 68.

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19 Open Arms

Summary

Open Arms is a nationally accredited mental health organisation funded by the Australian Government and run by the Department of Veterans' Affairs (DVA). It provides free and confidential mental health support and counselling.

The organisation began as the Vietnam Veterans' Counselling Service in 1982. It now provides a range of services to serving and ex-serving Australian Defence Force (ADF) members and others in the Defence community. These services are undoubtedly important in supporting mental health among serving and ex-serving members.

There has been rapid growth in demand for Open Arms services, particularly from 2017 to 2021. This led to pressure on the workforce and raised concerns in DVA about its sustainability.

Open Arms is unique, as it is the only clinical health service run by an Australian Government agency. We have heard how this poses challenges for service delivery.

Sadly, 200 individuals who were or had been its clients and were serving or ex-serving members died by suicide between 1 January 2013 and 30 June 2022.

Several reviews have been undertaken recently into Open Arms, including in response to 'adverse events' (deaths by suicide) among its clients. These reviews identified serious issues, including in its approach to clinical governance, workforce and documentation.

DVA also conducted a 'deep dive' into Open Arms because of concerns that it had not adapted to significant growth in the number of clients and its changing service offering. It considered whether its services should be outsourced (which it decided against).

Since the reviews discussed in this chapter, we have seen a number of positive changes. They include the launch of a new Open Arms 'Model of Care' in August 2023, and greater reliance on permanent staff over contractors.

As the changes have been very recent, it is difficult to assess their effectiveness. Several were enacted as we were drafting this report. Structural issues, including the appropriateness of the Open Arms service delivery arrangement, remain.

We therefore recommend a wide-ranging review of Open Arms begin in 2027. It should consider how Open Arms delivers services, its service offering, and whether the changes have improved service quality and clinical governance.

19.1 Introduction

1. Open Arms is a nationally accredited mental health organisation funded by the Australian Government and run by the Department of Veterans' Affairs (DVA). It provides a range of free and confidential counselling and other mental health support services. Open Arms clients are serving and ex-serving ADF members with at least one day of service, their partners and children and, in some circumstances, other family members.¹
2. The Australian Government established Open Arms as the Vietnam Veterans' Counselling Service in 1982.² Before this, the Vietnam Veterans' Association of Australia had run a peer program and then counselling. Following lobbying by the association, the Australian Government agreed to fund and run the service.³
3. Open Arms has been through several iterations. In 2007, it was renamed Veterans and Veterans' Families Counselling Service and services were extended to veterans of all conflicts and their families.⁴ It became Open Arms in 2018, and eligibility was further expanded. Its reach continues to grow.⁵
4. In the 2022–23 financial year, 43,173 clients accessed Open Arms services, up significantly from 16,472 in 2016–17. We discuss this growth in section 19.2.2.⁶ Today, Open Arms has a substantial footprint. As at 31 December 2023, Open Arms employed 277 in-centre clinicians and had a network of 1,205 Outreach Program counsellors.⁷

19.2 A unique and growing service

5. Open Arms is part of DVA.⁸ It is a standalone division that 'participates in ... broader DVA governance processes'.⁹ It is led by a member of the DVA executive.¹⁰
6. Open Arms is accredited under the National Standards for Mental Health Services.¹¹ To become accredited, organisations are independently assessed against these standards, which are established by the Australian Government Department of Health and Aged Care.
7. Open Arms has a National Advisory Committee. It provides the Minister for Veterans' Affairs and Defence Personnel with 'independent advice on the needs of the veteran community and how these can be addressed through Open Arms'.¹² Its members include clinicians, a social worker, representatives from different veteran communities, and those with lived experience. DVA, Defence and Department of Health and Aged Care staff are ex-officio members.¹³
8. Open Arms is mainly funded through DVA's budget, while the Department of Defence funds some counselling services.¹⁴ Its services are delivered by a blend of Australian Public Service employees, labour hire contractors, private contractors and outsourced providers from non-government organisations and private organisations such as Bupa, Centacare and Relationships Australia.¹⁵

19.2.1 A unique service delivery arrangement

9. The Australian Government does not directly deliver any other clinical service.
10. Clinical services are typically delivered by state and territory governments, and private and not-for-profit providers. The Australian Government funds counselling services such as the Suicide Call Back Service and MensLine Australia but they are commissioned and delivered by private providers.¹⁶
11. Then First Assistant Secretary of Mental Health and Wellbeing Services at DVA, Ms Leanne Cameron, told us of the challenges for DVA:

The tensions for Open Arms and DVA are that Open Arms is, to the best of my knowledge, the only direct healthcare service within the Commonwealth, so it's in a very unusual position. It is not something that is experienced by any other department. Most departments that have a role in health care are as either policymakers or funders.¹⁷

12. Previous reviews have noted this arrangement may have an impact on Open Arms's ability to deliver services effectively. The 2022 Quality Innovation Performance (QIP) *Accreditation Report*, an external review undertaken as part of Open Arms's re-accreditation (discussed in section 19.3.1), said:

Having a national mental health service sitting within a Federal Government Department is unusual and creates unique challenges including an understanding of the particular needs of this type of service delivery.¹⁸

13. DVA and other Australian Government departments have limited capacity for and expertise in delivering a clinical service. As Ms Cameron told us:

DVA's role in health care for the rest of the department, apart from Open Arms, is very much as a funder. So the role is quite different and requires different clinical governance.¹⁹

14. Also, the New South Wales Public Service Commission notes collaboration between public sector organisations can help build their capability, as organisations learn from one another.²⁰ There are no similar entities within the Australian Government for Open Arms to exchange ideas with and learn from.

19.2.2 Open Arms has grown quickly

15. Open Arms has experienced significant recent growth. The number of clients it sees, the services it offers and those eligible for its services have all increased. In 2018, Open Arms said it was evolving 'in line with both the expectations of its expanding client base and the increasingly sophisticated understanding of best practice treatment of military trauma'.²¹

An evolving service offering

16. Despite its inception as a counselling service, Open Arms now provides multidisciplinary services across 'the full spectrum of care'.²² In September 2021, DVA told us Open Arms provides:
 - 24/7 telephone support for clients to access the information and services they need, including one-off phone support and referrals and telephone counselling
 - counselling delivered by psychologists, mental health occupational therapists and nurses
 - group treatment programs, 'relationship retreats' and education programs, which focus on trauma recovery, sleep, anxiety, transition, parenting, relaxation and stress management, and anger management
 - community and peer programs, involving peers with lived experience of mental health issues and military service, who work with veteran communities, link them with Open Arms staff, and provide 'peer support and mentoring capability'
 - case coordination of care for clients with complex issues, outreach for vulnerable or at-risk clients, and referrals to accommodation and crisis services, specialist services or treatments, and DVA rehabilitation
 - digital platforms, including the 'Living Well' webpage, case studies and other resources for veterans and their families
 - research and pilot programs.²³
17. Open Arms updated its Model of Care, which details its services, in May 2024. It does not provide level 5 services, which involve specialist assessment and intervention for individuals with significant symptoms.²⁴ People who require level 5 services usually have significant symptoms, and may be:
 - at significant risk of suicide, self-harm and self-neglect
 - at significant risk of harming others
 - experiencing a high level of distress, with potential for debilitating consequences.²⁵
18. However, Open Arms may have a supporting role for those engaged with level 5 services. This includes helping clients navigate the health system, supporting discharge planning, and seeking acute and subacute mental health services where needed.²⁶
19. Its Model of Care also states it does not provide:
 - specialised family and domestic violence services (although client-facing staff are trained in assessing and identifying family and domestic violence risk)
 - services relating to the criminal justice system
 - services for children under 5 years old

- specialised assessment, including assessment or treatment for health conditions
- aged care and specialised mental health services for older people
- homelessness services (although it does provide referrals to community housing providers).

Expanded eligibility

20. Mirroring its growing service offering, eligibility to access Open Arms services has expanded. In 2018, the national advisory committee of Open Arms's precursor described this process:

Successive governments have committed to reviewing [Open Arms] client eligibility on an ongoing basis to ensure community needs are met. This has resulted in iterative expansions of [Open Arms] eligibility.²⁷

21. A major expansion occurred in April 2017, when eligibility was extended to:
- family members of serving and ex-serving ADF members who died by suicide or suspected suicide
 - siblings of ADF members killed in service-related incidents
 - Defence Abuse Response Taskforce complainants and their families
 - adult children of post-Vietnam War veterans.²⁸
22. Later in 2017, access was further expanded to the families of members with at least one day of continuous full-time service.²⁹ Family members now make up a significant component of Open Arms clients.
23. The Model of Care document lists those eligible to access its services, including:
- serving ADF personnel
 - ADF personnel transitioning to civilian life
 - ex-serving members
 - partners and children of serving and ex-serving personnel
 - ex-partners who are co-parenting
 - reservists with one day continuous full-time service or hazardous service.³⁰
24. In 2022–23, approximately:
- 19% of Open Arms clients were serving members
 - 28% were ex-serving members
 - 36% were family members
 - 17% were classified as representing other categories.³¹

25. Among these clients, the top three presenting issues were anxiety, depression and relationship issues.³²

Client growth

26. DVA told us the number of clients seeking out and using Open Arms support nearly doubled between 2015 and 2020.³³ It attributed this to the expansion of eligibility for Open Arms services in 2017–18.³⁴
27. Table 19.1 shows this growth, which was particularly acute from 2016–17 to 2020–21.

Table 19.1 Clients accessing Open Arms

Financial year	Unique client count	Change from previous year (%)
2016–17	16,472	–
2017–18	20,839	27
2018–19	24,852	19
2019–20	30,967	25
2020–21	38,073	23
2021–22	40,914	7
2022–23	43,173	6

Source: Exhibit S-01.049, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-163, DVA.9999.0154.0001 at 0011 [13.2].

19.2.3 A growing service poses issues

28. Open Arms's growth has posed challenges. In the following section, we discuss the impact of this rapid growth and its implications for Open Arms in terms of:
- financial sustainability
 - the workforce, including its composition and ability to meet the needs of Open Arms clients.

DVA suggested that aspects of the organisation had struggled to keep pace with its growth – something we discuss in section 19.3.1.³⁵

Financial sustainability

29. In 2020, DVA conducted a deep dive into Open Arms (discussed in section 19.3.1), which noted the financial impact associated with the growing demand for its services. It stated:

Open Arms Administered Clinical Services have grown rapidly over the past four years:

– Total expenditure up from [\$]28.1m in 2016/17 to a forecast of \$94.8m in 2020/21³⁶

30. The document listed financial issues relating to demand outpacing funding as a ‘potential risk’.³⁷ It noted ‘[d]epartmental funding and ASL (average staffing level) has not grown with growth in demand (25% growth pa over last four years)’.³⁸
31. However, in 2024, DVA told us the organisation was ‘well funded’, suggesting this risk did not eventuate.³⁹ The National Manager, Ms Leonie Nowland, did not raise resourcing as an issue when asked what major changes she would like to see with Open Arms. In fact, she noted:

I do have to say, we are well funded. We are the only well-funded mental health service I think I’ve ever worked in and I’ve worked in New Zealand and in the UK and across Australia.⁴⁰

32. Indeed, expenditure on Open Arms has steadily and significantly increased. The deep dive showed that \$32.5 million was spent on Open Arms functions in 2016–17.⁴¹ DVA’s 2024–25 Portfolio Budget Statement shows Open Arms has been allocated more than \$134 million for 2024–25.⁴² While the two sources may not be ‘like for like’ comparisons, they provide an insight into the scale of Open Arms’s growth.
33. Expenditure is forecast to increase slightly in the 2026–27 financial year, then decline.⁴³ DVA noted the new Model of Care defines Open Arms’s scope of practice.⁴⁴ For example, since the model was implemented, there has been a ‘significant decrease’ in requests for crisis accommodation (the model states that Open Arms is not a specialised provider of homelessness services).⁴⁵
34. The services Open Arms delivers should benefit from continued funding. For this to occur, Open Arms must demonstrate it will be sustainable over the long term. This, too, raises questions about the appropriate service delivery arrangement, and whether the current approach represents a sustainable model, and one that provides value for members, veterans and their families.

Workforce issues

35. Significantly increased demand and an expanded service offering also raises questions about the capacity of the Open Arms workforce to respond.

Workforce composition

36. A key QIP report finding related to the composition of Open Arms workforce, and its potential to adversely impact the quality of its services.
37. The report said that in August 2022 around 65% of the Open Arms workforce were labour hire workers.⁴⁶ This was partly due to limitations on establishing new (permanent) Australian Public Service positions, enforced through the ASL cap.⁴⁷
38. This is a high proportion of contracted staff. The QIP report noted ‘it was not clear ... that this arrangement was effective [or] how it met all compliance requirements of a mental health service workplace’.⁴⁸
39. It said it posed ‘significant’ risks, including:
- high staff turnover
 - workforce management issues
 - costs associated with recruitment and training when staff leave
 - the ownership of client information and records of clients seen by mental health professionals under the BUPA contract.⁴⁹
40. The QIP report said ‘it [was] not clear how performance management, and other expected human resource functions occur within Open Arms, and how Open Arms policy can be enforced on labour hire staff’.⁵⁰ It noted staff raised concerns about the uncertainty of being contracted, and not having standard working conditions like sick leave and annual leave.⁵¹
41. The report noted that DVA’s Mental Health and Social Wellbeing Division Risk Register identified several workforce issues but was ‘silent’ on the risks associated with Open Arms’s reliance on a majority-contractor workforce.⁵²
42. Since the QIP report was published in 2022, the Australian Government has removed the ASL cap and Open Arms has offered labour hire workers non-ongoing contracts. As at 31 December 2023, only 19% of the Open Arms workforce was engaged on labour hire contracts.⁵³ We recognise this is a positive step that will address some of the issues raised in the QIP report.
43. However, Open Arms continues to rely on a large and diverse workforce. It operates in multiple locations nationwide, has staff from a range of professional backgrounds, and still includes labour hire staff as well as permanent workers and those on non-ongoing contracts.

Ability to meet client demand

44. People told us that they experienced long wait times to access Open Arms services.

45. Dr Francis Donovan OAM served in Vietnam and was a co-founder of the Vietnam Veterans Counselling Service (the precursor to Open Arms). In a submission to the Royal Commission, Dr Donovan said Open Arms clients were experiencing:

- long wait times, delays and ‘invasive intake protocols’
- a ‘more remote and less personal response’.

46. Dr Donovan said this was due to a ‘greater emphasis on managing increased intake numbers’ following the sharp increase in demand for its services.⁵⁴ He said this information was anecdotal, communicated by clients and Open Arms staff through ex-service organisations.⁵⁵

47. Several submissions talked about wait times experienced by Open Arms clients. Some of these refer to accessing the service during, or after, the period of rapid client growth.

48. One submission, which we received in 2021, spoke about how long wait times can seriously impact individuals in distress:

At peak times, there can be a two-month wait to even have an intake, which is not even the start of therapy and a further month or so to actually speak to a psychologist. I will let you draw your own conclusions to how this might affect someone who might already be on the verge of ending his/her own life.⁵⁶

49. One individual spoke of the lack of support provided by Open Arms during a crisis that they experienced in 2019, which had a deep personal impact:

In [redacted], I was severely struggling with depression after my marriage breakdown and my negative and haunting thoughts following Afghanistan. I remember being on the phone to Open Arms, lying on the toilet floor in the foetal position at my work place crying and asking for help. They were not able to get me an appointment to speak with anyone for another week. Because I wasn’t ‘suicidal’ that was the best they could offer. A few days after that episode, I was taken to hospital by ambulance after an overdose of prescription drugs.⁵⁷

50. We are aware these are individual experiences. However, they speak to the profound importance of timely access to appropriate care, especially for those who are experiencing distress.

51. Open Arms’s *Brief summary of reviews: July to December 2020* also flagged potential issues with delays. It proposed the leadership team consider, as a ‘suggested improvement’, the need for:

auditing of timelines between Open Arms’ intake-to-allocation of clients, including frequency of lengthy delays. If widespread issues are identified, identify and address systems and processes, to ensure such delays are minimised.⁵⁸

52. The DVA's *Annual Report 2021–22* states that in those 12 months 87% of Open Arms clients were *allocated* to a clinician within 2 weeks of intake.⁵⁹ A smaller proportion (57%) were actually *seen* by a clinician within 2 weeks.⁶⁰ On average, a client had to wait around 22 days before seeing a clinician in 2021–22, a figure which declined to around 20 days in 2022–23.⁶¹
53. In October 2022, Ms Nowland said Open Arms currently has 'a waitlist across the country of 500 clients thereabouts'.⁶²
54. DVA attributed delays in the allocation of clients to issues such as the mental health clinical workforce shortage across Australia, or clients requesting a particular clinician.⁶³ It said Open Arms offers alternative support, including via a peer worker, to clients awaiting allocation.⁶⁴
55. In 2024, DVA told us the Open Arms 'Wait list and Allocation project' had begun, and it will 'define national standards and improve regional capacity to manage client demand and resource allocation'.⁶⁵

19.3 Clinical governance and organisational issues

56. According to data provided by Open Arms, between 1 January 2013 and 30 June 2022, 200 individuals who were Open Arms clients, and were serving or ex-serving members, died by suicide (suspected, possible or verified).⁶⁶
57. Thirty-three clients were in contact with Open Arms within 7 days before their death, 31 within 8 to 30 days, 15 within 31 to 90 days, and 30 within 91 days to 1 year. The remaining 90 had not been in contact with Open Arms within a year. Open Arms could not specify the last date of contact for one individual.⁶⁷
58. The nature of Open Arms services, and the vulnerability of some of its clients, means the tragic outcome of death by suicide does not in itself imply failings on the part of the organisation. However, these statistics are very concerning, particularly in light of the issues raised in subsequent reviews. We also note our inquiry has not compared these outcomes against those of similar services.
59. They also highlight the importance of clinical governance. Clinical governance is the set of relationships and responsibilities established by a health service organisation, including with its management, workforce, patients and other healthcare organisations.⁶⁸
60. In Chapter 14, Introduction to health care for members and veterans, we outline the importance of effective clinical governance ensures safe and high-quality health care, and good clinical outcomes.
61. Improved clinical governance is also a priority for Open Arms. Ms Nowland told us it was one of her priorities for the organisation.⁶⁹

19.3.1 Recent reviews of Open Arms

62. Open Arms has been subject to several recent reviews, which identified sometimes serious issues with the way the organisation operates.
63. Following the suicide or suspected suicide of a serving or ex-serving Open Arms client, a review is undertaken that seeks to identify issues (including with policy or practice) and suggest changes.⁷⁰
64. In 2020, two summary reviews were undertaken, and the results outlined the issues Open Arms was experiencing at that time:⁷¹
 - Adverse Event Reviews (Suspected Suicide) January 2019 – June 2020
 - Brief summary of reviews: July to December 2020.
65. An external report, the 2022 QIP report, was completed when Open Arms was assessed against the National Standards for Mental Health Services in 2022.⁷²
66. All of these reviews identified clinical issues within Open Arms.
67. DVA also explored organisational changes in the context of growing demand for Open Arms services. It set out options in the document 'Open Arms Deep Dive 2020'.

Adverse Event Reviews (Suspected Suicide) January 2019 – June 2020

68. In 2020, Open Arms reviewed adverse events involving the suspected suicides of clients between January 2019 and 30 June 2020.⁷³ This involved analysing the results of reviews of 30 suspected suicides.⁷⁴
69. The review focused on 'facilitating ongoing improvement', including 'issues identified in the process of delivering care as well as some suggestions regarding the way in which Open Arms services are provided'.⁷⁵
70. Of the 30 client records reviewed as part of this work, 25 (or 83%) were identified as having 'significant issues with compliance, clinical quality, and completeness'.⁷⁶
71. The most common issue related to documentation. According to the review summary, '[t]here were significant absences, low quality of entries, and poor organisation. These were found in 56% of adverse events reviewed'.⁷⁷
72. The summary findings noted:

The issues related to documentation raise questions regarding the quality of clinical services – for example, are the issues that were identified with client-facing activities the result of poor professional practice or, rather, the poor recording of the associated professional activities? Answering such questions is beyond the scope of this summary.⁷⁸

73. It noted postvention services were an area of particular concern:

Of particular note was the lack of consistency in the documentation of the postvention activities undertaken after the death of the client. For example, information about the postvention activities undertaken was documented in only 40% of the clients' records. This may be because it was provided in the records of (e.g.) clients' families.⁷⁹

74. It grouped issues under three themes: 'documentation', 'client-facing activities' and 'process'. In Box 19.1, we have set out in full the issues the review identified.

Box 19.1 Issues raised in the Adverse Event Reviews (Suspected Suicide) January 2019 – June 2020

Documentation

- Poor quality of, disorganisation of, and/or significant absences in the documentation of episodes of care in the electronic records management system.
- Apparent lack of understanding by outreach program counsellors ... of the client's CMS records management system.
- Retrospective modification of the CMS records, post-adverse event, with no indication of what information was changed and why. NOTE: This has potential legal and ethical implications.
- Lack of clear documentation in the CMS records on the conduct and nature of postvention follow-up activities undertaken for family members and significant others.

Client-facing activities

- Less than optimal quality of care coordination / management of clients with complex needs.
- Lack of demonstrated knowledge, skills or understanding of what is involved in complex case management / care coordination, including:
 - care planning
 - team-based case planning
 - team-based co-management and support for clients, to reduce likelihood of burn-out
 - the need to work with other agencies or service providers
 - the importance of conducting/documenting ongoing and comprehensive risk assessments that include the multiple factors affecting risk.

- Lack of a demonstrated efficient use of the client's first session to engage and build a relationship, and thereby encourage the client's return.
- Lack of recorded contact or collaboration between Open Arms and health professionals from other services or organisations (such as psychiatrists, GPs, state-run health professionals including community health teams, other veteran services), particularly when supporting complex cases.
- Lack of documented follow-up with clients after information was received from external service providers identifying concerns with levels of risk and findings of mental health assessments.
- Premature closure of cases, particularly for clients with complex needs.

Process

- Lack of a demonstrated understanding of the role of 'care coordinator' for clients with complex needs.
- Lack of exchange of information (with consent) between Open Arms and health service providers (such as state-based health services or private hospital providers) for clients with complex needs.
- Lack of exchange of information (with consent) between Open Arms and DVA for clients with complex needs to enable effective management and coordination.
- Lack of timeliness between initial intake, allocation of counsellors, and commencement of counselling, with no documented/recorded check-in by Open Arms.
- An apparent inconsistent follow-up of clients between initial intake, allocation of counsellors, and commencement of counselling, particularly when allocation or commencement is delayed.
- An apparent lack of communication by Open Arms with clients on waiting lists.
- Lack of referrals to external health professionals, including specialist medical practitioners, to support collaborative care of clients with complex needs. This is a particular concern for long-term clients with ongoing issues who have not been trialled on pharmacotherapy.
- Lack of straightforward referral processes to external health professionals, including specialist medical practitioners, to support collaborative care of clients with complex needs. This is a particular concern for long-term clients with ongoing issues who have not been trialled on pharmacotherapy.
- An apparent lack of proactive follow-up of clients-in-distress who have rung for support over the Christmas/New Year period.

- Lack of follow-up of clients after they have been discharged from hospital after a suicide attempt.
- Issues in management of clients with chronic suicidality, including the provision of support for the outreach program or centre-based counsellors who undertake this stressful work.
- Gaps in communication between Open Arms's managers and outreach program counsellors, particularly in relation to follow-up with clients who had been assessed with moderate-to-high levels of risk.
- Lack of consistency in relation to who is informed of the death (for example, external health service providers) after receipt of death notification.⁸⁰

Brief summary of reviews: July to December 2020

75. A summary report was completed of reviews of 16 of 21 suspected deaths by suicide between 1 July and 31 December 2020.⁸¹
76. Sixteen client records were reviewed (the other five clients had not engaged with Open Arms in the previous 12 months).⁸² Of those reviews, 11 identified 'issues with the way Open Arms delivered services'.⁸³
77. The summary identified 'common themes', such as:
 - unsatisfactory standards of documentation, including a lack of or no information entered in client records, and retrospective altering of information after a client's death
 - procedures were not followed relating to the delivery of clinical care to clients or their families
 - support (including counselling support) provided to clients or their families did not 'seem to meet' required standards.⁸⁴
78. It reiterated some recommendations from the 2020 review, including around training for Open Arms workers.⁸⁵ It also recommended an audit of Open Arms's timelines (from intake, to allocation, referral and the first session) to identify if delays were 'systemic'.⁸⁶

Open Arms Deep Dive 2020

79. In 2020, DVA undertook a short review that examined the appropriate structure for Open Arms and how its services should be delivered.
80. The context was the growth that Open Arms had experienced, and consideration of whether Open Arms should remain in DVA. Then First Assistant Secretary of Mental Health and Wellbeing Services at DVA, Ms Leanne Cameron, told us:

So in terms of specific consideration, I am aware that as recently as about three years ago, certainly some options were put together about whether Open Arms would remain with DVA or not, and they were considered by the current Secretary.⁸⁷

81. Separately, DVA told us it undertook work in 2020 in response to the question of whether Open Arms had the 'correct organisational structure'.⁸⁸ It said 'the impetus for this was the significant growth in clients seeking and utilising Open Arms support between 2015 and 2020'.⁸⁹

82. It also suggested that Open Arms was not responding well to this growth, stating:

the management of Open Arms had not changed to take account of this rapid expansion and changing service delivery platform. The span of control, span of risk, and locus of control had not kept pace with the changing function.⁹⁰

83. In response, DVA developed the document called Open Arms Deep Dive 2020. This set out the options for where Open Arms might sit if it were not in DVA.⁹¹

84. Based on our analysis, the 'deep dive' considered three options. Open Arms could:

- remain within the Defence portfolio, but with separate funding
- remain within the Defence portfolio as a separate entity, such as a statutory agency, a non-corporate Commonwealth agency, or a corporate Commonwealth entity
- outsource its services to an external provider, with DVA managing the contract.⁹²

85. DVA briefly analysed the risks and benefits of each option. It did not just focus on the implications for quality of care, clinical issues or clients' experiences. It included seven 'political' and nine 'reputational' considerations.⁹³

86. The document did not engage meaningfully with the drawbacks of having a clinical service delivered by an Australian Government agency. It did, however, say that a benefit of the outsourced model would be 'enhanced opportunities for consistency and quality control in [Outreach Program counsellors] services'.⁹⁴

87. In the end, DVA decided to retain Open Arms. DVA said this acknowledged ‘likely concerns from the veteran community if the service were to be outsourced’.⁹⁵ It told us then Secretary of DVA, Ms Elizabeth Cosson AM CSC (Major General Retd), was ‘keen to ensure support services to veterans could be integrated and coordinated across DVA to provide a better client experience’.⁹⁶
88. DVA also told us of the benefits of Open Arms operating as part of the department. It said this arrangement supports better collaboration with DVA case managers, Open Arms’s participation in policy development, and alignment of its services with the veteran experience.⁹⁷
89. A number of organisational changes were also made, which we outline in section 19.4.

The 2022 Quality Innovation Performance report

90. As an accredited mental health service, Open Arms must undergo periodic re-accreditation. It was last assessed against the National Standards for Mental Health Services in 2022. This involved an independent review of the organisation and its practices against the standards set out by the Australian Government Department of Health and Aged Care.⁹⁸
91. This work was led by Quality Innovation Performance (QIP) Limited, a private company. QIP produced an accreditation report with findings and recommendations.⁹⁹
92. As a result, Open Arms was successfully re-accredited against the National Standards. The QIP report identified a number of Open Arms ‘key strengths’, including the depth and breadth of its service offering, its understanding of the role of carers and families, and its transition to a 24/7 service during COVID-19.¹⁰⁰
93. It identified 11 ‘areas for improvement’, including:
- governance arrangements
 - workforce pressures
 - change management approaches
 - management of corporate and clinical risks
 - monitoring and outcomes
 - the role of the external National Advisory Committee.¹⁰¹
94. A number of report findings addressed clinical governance issues (see Box 19.2).
95. The QIP report also raised issues with the Open Arms workforce, which we discuss in section 19.3.2.

Box 19.2 QIP clinical governance issues

On informed consent:

Assistant Directors and clinicians indicated that completed informed consent forms confirm that care delivered is subject to informed consent; however, the form may not always be uploaded although the case notes indicate that informed consent has been provided by the client.¹⁰²

On rights and responsibilities:

Not all sites visited had rights and responsibilities on display or available for clients to take away. Audit all sites and ensure that rights and responsibilities information is displayed and available for clients to either read or take.¹⁰³

On consumer feedback:

Most clients felt confident to make a complaint or offer feedback; however, the majority did not recall being informed about this process and said that they could negotiate how to find this information for themselves.¹⁰⁴

On risk management:

while there was a range of risk management documents and registers presented these did not all seem to link well to each other, nor cascade down through the various divisions of DVA. The risk registers seen were in excel spreadsheets, which appear insufficient to comprehensively manage risk across the whole of DVA.¹⁰⁵

19.3.2 Other issues ascribed to Open Arms

96. Our inquiry heard evidence about several other issues related to Open Arms, which we outline in the following section. Some of these align with issues previously identified in the reviews covered earlier in this section.

Coordination of care across agencies

97. The Royal Commission heard information does not always flow appropriately between Open Arms and Defence, DVA, ex-service organisations and other civilian services.
98. Coordinated care is very important where a client is at risk. The *Adverse Event Reviews (Suspected Suicide) January 2019 – June 2020* report identified issues with communication between Open Arms and other health services. It said that the management of clients with complex needs was affected by a lack of information sharing between DVA and Open Arms.¹⁰⁶

99. Dr Jonathan Lane is a serving member and Senior Lecturer in Psychiatry at the University of Tasmania. Before his appointment in 2023 as Open Arms Senior Psychiatrist, Dr Lane told us that in 2022 coordination between Open Arms and other entities was inadequate. He said this had implications for patient care:

Open Arms does not generally collaborate with the rest of the healthcare system, does not have ANY psychiatrists on staff, and does not provide clinical information to anyone outside their own system in any form of systematic manner. This means that this counselling service operates as an isolated entity that actively prevents collaboration and multidisciplinary care, despite being the 'primary' service for mental health for veterans. The ADF and Open Arms are therefore closed entities that operate in isolation to the rest of the healthcare world, which adversely impact[s] the ability to share-care for veterans, and effectively manage their needs.¹⁰⁷

100. DVA told the Royal Commission it recognises 'historical issues' related to insufficient information flow between Open Arms and other entities.¹⁰⁸ It said that it recognises the 'need for engagement and communication between Open Arms and Defence, DVA, ex-service organisations and other civilian services'. It said that measures like the new Model of Care, the Veteran Identifier and improvements to its intake and referral systems (discussed in Chapter 17, ADF and DVA suicide prevention programs and initiatives) would enable better coordination and referral across services.¹⁰⁹
101. It also noted the role of revised consent forms for sharing data between Open Arms and DVA. It cited initiatives like transition seminars and on-base DVA services, which provide a 'warm handover' for transitioning members to Open Arms and its services.¹¹⁰ While we support the intent of these initiatives, we do not consider that the transition seminars have effectively engaged members, as we discuss in Chapter 23, Transition from military to civilian life.

The expertise of Open Arms staff

102. We have heard concerns Open Arms staff do not always have the qualifications required to meet clients' needs.
103. A co-founder of the Vietnam Veterans Counselling Service (the precursor to Open Arms), Dr Francis Donovan OAM told us there was a lack of 'war-trauma informed skills' within Open Arms. He said this has occurred since eligibility to access Open Arms services was expanded. He told us the growing demand had put counselling staff under pressure and had resulted in 'generic and less specialised' counselling.¹¹¹
104. Dr Donovan told us increased demand was making it more difficult for Open Arms to hire appropriate staff:

In May 2023, I attended an Open Arms Regional Advisory Forum. There I learned that recruitment of suitably qualified and accredited, appropriately skilled and clinically experienced counselling staff had become a major challenge. Management had become obliged to look beyond the mainstream

disciplines of Mental Health and Clinical Social Work and Clinical Psychology with trauma-informed skill sets, in order to meet the burgeoning demand from a much bigger pool of eligible claimants.

That situation Commissioners, in my view and that of the VVAA [Vietnam Veterans' Association of Australia], poses a real and direct risk to the mental health of veterans returning and transitioning with war-caused mental health trauma, related PTSD and/or other conditions acquired in their active service with the ADF.¹¹²

105. In an August 2022 statement to the Royal Commission, Dr Lane told us Open Arms did not have psychiatrists on staff. This led to the siloing of individual services and made it difficult for its counselling service to provide true 'multidisciplinary' care.¹¹³

106. The QIP report found Open Arms met the National Standards criteria specifying that 'the recruitment and selection process of the MHS [Mental Health Services] ensures that staff have the skills and capability to perform the duties required of them'.¹¹⁴ However, it also said attention should be paid to 'ensuring that key decision-makers have an understanding of clinical mental health service'.¹¹⁵ It said:

There was concern expressed that while support staff who previously sat within Open Arms had clinical expertise and made decisions based on their knowledge of mental health services, that these people may be replaced by people who do not have this knowledge, and will not have sufficient understanding of clinical service delivery.¹¹⁶

107. We also heard about this from those who use Open Arms services. One individual said in a submission:

Psychologists often fail to listen to veterans and do not have the skills, experience and qualifications to perform their roles.¹¹⁷

108. DVA told us it requires regional office directors to have relevant mental health qualifications and expertise. These are qualifications as a registered psychologist, mental health occupational therapist or mental health registered nurse with full Australian Health Practitioner Regulation Agency registration; or as a social worker eligible for membership of the Australian Association of Social Workers.¹¹⁸

109. Dr Lane began working as Open Arms Senior Psychiatrist in 2023, providing high-level policy advice, and advice on high-risk clients.¹¹⁹ According to DVA, this role 'has been instrumental in development of clinical governance, quality assurance, the Model of Care and formalising a consistent approach to risk assessment'.¹²⁰

110. DVA told us in June 2024 that it had also established a Chief Psychiatrist position. The role will 'provide dedicated psychiatric expertise to support clinical governance across our mental and social health programs (i.e. not just for Open Arms) and will promote continuous improvement in DVA'. It said this position will be 'pivotal to DVA supporting the best mental health outcomes for veterans'.¹²¹

111. We welcome any effort to embed clinical knowledge within DVA (and Open Arms). However, the appointment of Dr Lane and, even more so, the establishment of the Chief Psychiatrist position have occurred so recently it is not possible to assess their impact.
112. More broadly, it is important that Open Arms maintain a staffing profile that is appropriate for the range of mental health services it provides – in addition to counselling. These efforts should be complemented by an effective clinical governance system.

Awareness of Open Arms services

113. Despite the sharp increase in demand for its services between 2016 and 2021, regional advisory forums Open Arms hosted between April and July 2021 reported low awareness of it among some serving and ex-serving members.¹²²
114. Participants suggested undertaking measures to increase awareness of Open Arms. These included establishing collaborative service agreements between Defence and DVA, embedding Open Arms peers within Defence bases, enhancing visibility of Open Arms programs, and increasing the sharing of lived experience stories focused on transition and recovery.¹²³
115. Previous inquiries had emphasised the importance of greater service awareness. In its response to the 2017 Senate Inquiry report *The Constant Battle: Suicide by Veterans*, the Australian Government agreed that funding should be provided to Open Arms to create a public database of services and provide information assistance to connect veterans and families with needed services.¹²⁴ This resulted in a website that was operated by Defence, rather than DVA.¹²⁵
116. We also heard about the importance of service awareness from those with lived experience. Ms Caroline Hofman, a veteran, told us that, despite her positive experiences, the veteran community lacks awareness of Open Arms services:

Whilst access to Open Arms is available, and I will say that my interaction to counselling services has been positive, it is not widely known in the veteran community. Very few veterans belong to groups and DVA or Defence only send out token letters/emails informing people of activities. If you are not in the DVA distribution system you are invisible. I am in the system, yet I am still invisible.¹²⁶
117. DVA disagrees there is poor awareness of Open Arms services. We acknowledge the sharp increase in demand for its services and the lengths to which Open Arms and DVA go to promote it.
118. Despite this, given evidence and information that some people are still not aware of its services, we encourage Open Arms to continue to find ways to promote them.

119. Open Arms promotes services through activities that include:
- providing information on its website, including about the 24/7 contact service
 - running proactive social media campaigns
 - advertising in publications targeted at veterans, and on other organisations' websites
 - using social media channels to connect with a large audience.¹²⁷
120. Open Arms established an 'overarching communications strategy' in 2021, which included 'tactics to promote awareness'.¹²⁸ Its objectives include increasing awareness of Open Arms, and promoting it as an employer of choice for mental health practitioners.¹²⁹

19.3.3 How do clients experience Open Arms?

121. Internal DVA data indicates the majority of Open Arms clients are satisfied with its services – 90.73% in the 2022–23 financial year.¹³⁰ This result is based on just 410 responses.¹³¹ We note in the 2022–23 financial year, 43,173 clients used its services.¹³²
122. Similarly, Open Arms data for the same period indicated it consistently received more compliments than complaints. However, this was based on only 860 cases.¹³³
123. We note the 2022 QIP review, discussed in section 19.3.1, found limited awareness of the feedback process. It said, while most Open Arms clients:
- felt confident to make a complaint or offer feedback ... the majority did not recall being informed about this process and said that they could negotiate how to find this information for themselves.¹³⁴
124. We also heard, through submissions and lived experience testimony, from many people who accessed Open Arms. They had diverse experiences: some clients benefited from its services, while others did not.
125. Some submitters told us of the positive, even profound, personal impact of Open Arms services. One individual said the support saved their life:
- I put my life being saved down to the Open Arms counselling service being available in the early hours of the morning when my health significantly deteriorated and there was no other support available.¹³⁵
126. Another submission said:
- It was only through the intervention of my 15-year-old son that the [suicide] attempt was [non-fatal] and since then I have received some remarkable support from my psychiatrist and organisations like Open Arms.¹³⁶

127. Other submissions spoke of a lack of, or a negative, impact. Mr Indiana Harding, an ex-serving Army member, told us:

‘Open Arms’ for me was useless. It offered no guidance on the way forward and the repatriation programs were not well thought out to make them suitable.¹³⁷

128. We recognise that these experiences are deeply personal, and will be shaped by factors that may vary, depending on the circumstances. We also understand that, given its large client base and the breadth of its service offering, there will be a wide range of experiences.

129. Previous reviews have also communicated a broad range of views on Open Arms, including from individuals and organisations representing serving and ex-serving members.¹³⁸

The need to better understand Open Arms’s impact

130. DVA does not publish Open Arms outcomes data, which limits the ability to assess the effectiveness of its services.

131. Open Arms uses standardised tools to measure the clinical outcomes of individuals and groups taking part in its clinical services and programs.¹³⁹ It told us the outcomes measures it uses include the Depression Anxiety Stress Scale, Alcohol Use Disorder Identification Test and the Diagnostic and Statistical Manual (5th edition) PTSD Checklist.¹⁴⁰

132. However, DVA told us that the use of this data is limited. It is ‘not recorded in a way that the information system can be interrogated to provide aggregate data on client outcomes’.¹⁴¹ Open Arms’s CMS also has limited capability.¹⁴²

133. DVA also told us it has limited oversight of community-based outcomes, which limits its ability to ‘provide meaningful data for community-based programs’.¹⁴³ While it did not specify the type of programs this encompasses, it could mean those targeting groups (not individuals), such as its community and peer programs.

134. This means there is limited ability to identify trends, assess the effectiveness of interventions, or compare results across different demographics or time periods. This inability to assess Open Arms services was identified by the Productivity Commission in its 2019 report *A Better Way to Support Veterans*.¹⁴⁴

135. DVA told us that it ‘agrees that there is a need to improve its collection, analysis and reporting of Open Arms data’.¹⁴⁵ It said Open Arms was ‘taking steps’ to ‘evaluate and implement lessons learned through the collection and analysis of data’, and noted it had begun work to develop a new case management system.¹⁴⁶

136. Our proposal for DVA to develop a more sophisticated monitoring and evaluation capacity could help with gathering this information (see Chapter 18, Health care for ex-serving members). Doing so would better inform DVA decisions around the services that Open Arms provides and how they are delivered.

19.4 Open Arms' response to issues identified in reviews

137. DVA told us it has made improvements, including in response to the reviews outlined earlier in this chapter. A number of these changes involve strengthening its clinical governance.

19.4.1 Response to the Adverse Event Reviews

138. DVA told us it had made changes in response to the *Adverse Event Reviews (Suspected Suicide) January 2019 – June 2020* report, including:
- introducing a new Model of Care, which we discuss later in this section
 - developing a DVA enterprise postvention framework, which it said was due to be developed in 2024
 - creating new minimum requirements for clinical documentation
 - establishing a new Learning and Development section to oversee the training of clinical and administrative staff
 - strengthening its audit process
 - reviewing processes and procedures to support episodic engagement
 - reviewing its CMS.¹⁴⁷

19.4.2 The Accreditation Improvement Plan

139. Following its 2022 accreditation against the National Standards for Mental Health Services, Open Arms developed an Accreditation Improvement Plan.¹⁴⁸ DVA told us the plan was approved in early August 2023 and a copy provided to QIP.¹⁴⁹
140. DVA told us it has established a new clinical governance branch, focused on 'strengthening clinical governance and enhancing learning and development'. It will include 'lived experience' and 'quality and safety' sections to improve clinical oversight of the organisation.¹⁵⁰ It said the branch will help address the plan's objectives.¹⁵¹
141. Open Arms cited other initiatives, including:
- (1) the formation of a Quality and Safety Team to lead quality improvement activities across Open Arms to ensure accountability of Open Arms' clinical service delivery, governance, processes and procedures

- (2) development of a Quality and Safety Review Procedure to undertake clinical reviews where current or former Open Arms' clients have died by confirmed or possible suicide or by misadventure, and to contribute to the continuous improvement of Open Arms' systems, procedures and processes
- (3) the formation of a Quality and Safety Committee to provide governance over the Quality and Safety Review process
- (4) completed review of the provision and accessibility of information, such as Rights and Responsibilities
- (5) re-establishment of the National Advisory Committee (NAC) to Open Arms.¹⁵²

Model of Care

- 142. In August 2023, the DVA Executive Management Board endorsed a new Open Arms Model of Care, developed in consultation with clinical staff, people with military lived experience, and senior mental health clinicians.¹⁵³
- 143. Open Arms published the model on its website in November 2023.¹⁵⁴ It published an updated version in May 2024.¹⁵⁵
- 144. DVA told us the Model of Care is designed to:
 - (1) clearly articulate what Open Arms does and does not do
 - (2) accurately reflect the legislative, budgetary and policy authorities under which Open Arms operates
 - (3) situate Open Arms appropriately within the overall mental health sector.¹⁵⁶
- 145. The Model of Care states Open Arms operates on the basis of 'episodes of care'. It takes a staged care approach to provide the appropriate level of care for each client, recognising that not all clients require the same level or type of support.¹⁵⁷
- 146. The five stages of care range from low-intensity services for those who are largely able to self-manage, or who may need short-term interim support while awaiting allocation to a clinician, to more intensive support for those who need it and have multiple and complex needs.¹⁵⁸
- 147. The Model of Care also specifies the services Open Arms does not offer, which we discuss in section 19.2.2.¹⁵⁹
- 148. DVA said it reviewed other models when developing the Model of Care, which is based on clinical best practice and the principles of trauma-informed care. DVA told us the model aligns with the National Standards for Mental Health Services Guidelines, against which Open Arms is accredited.¹⁶⁰

Comparing Open Arms Model of Care

149. We undertook a brief comparison with the 2017 Model of Care employed by the Jamie Larcombe Centre, which provides mental health and PTSD services to veterans in South Australia. While the service offering is different, the comparison is instructive.

150. The published version of the May 2024 Open Arms Model of Care:

- is 23 pages, plus two pages of appendices
- does not include definitions for terms such as ‘complex clients’ and ‘complex needs’
- does not set out who it was developed with (DVA told us it consulted with Open Arms clinicians and specialist GP and psychiatrist advisers, among others)¹⁶¹
- does not list draft versions of the document on its version history
- does not set out which services should be provided by different categories of Open Arms staff (for example, psychologists, social workers, occupational therapists, mental health nurses and counsellors), and when they should be provided
- does not include an overarching list of evidence or research that informed the model (DVA said it was informed by a number of models and policies used by Australian and state and territory government agencies, and private practices)¹⁶²
- does not situate the document among other DVA strategies or frameworks.¹⁶³

151. By comparison, the Jamie Larcombe Centre’s 2017 Model of Care:

- is 52 pages
- includes detailed definitions of key terms like ‘veteran’, ‘veteran community’, ‘carer’, ‘patient-centred care’ and ‘comorbidity’
- sets out the role of different categories of staff, including social workers, pharmacists, occupational therapists and psychiatrists
- has a reference list that includes published research
- lists people who were involved in its development, including members of the relevant working group
- sets out the 17 policy directives and plans the model aligns with.¹⁶⁴

Changes to organisational structure

152. Following the 2020 deep dive, DVA created a new Mental Health and Wellbeing Services Division to bring together Open Arms and Coordinated Client Support, ‘two areas focused on supporting the most vulnerable clients’.¹⁶⁵
153. In July 2023, another restructure saw Open Arms become a standalone division within DVA. DVA told us that this occurred because ‘Open Arms is a large and significant clinical support service, and in view of its significance and contribution, it needed to be a separate division’.¹⁶⁶
154. DVA told us this meant a ‘more streamlined governance and reporting relationship with DVA, with direct FAS (First Assistant Secretary) representation in the executive leadership group’, and that it ‘increase[s] internal accountability’.¹⁶⁷
155. We asked DVA if operating Open Arms from within the department posed challenges or barriers. Its answer cited privacy and information sharing issues, suggesting there may be a tension between managing personal information and providing support for complex clients.¹⁶⁸
156. It did not talk about the issues that prompted the deep dive, such as managing the service’s rapid growth and the challenges of being the sole Australian Government clinical services provider.

Considering the adequacy of Open Arms’s response

157. The issues raised in the reviews discussed in section 19.3.1 are serious and widespread. A response was needed, and we commend Open Arms for recognising this.
158. The focus on clinical governance, including the new Model of Care, is justified. Although the model may have shortcomings, it is important that this work progresses and is given time to mature and have an impact on practice.
159. However, we note three qualifiers around the response:
- Some of the reforms have only recently been announced or implemented, which makes it difficult to assess them.
 - The gravity of the issues raised in the reviews means they may be difficult to address quickly. They may require sustained reform to remedy, which can require time, funding and leadership commitment.
 - It is not clear whether the issues identified are due to the Australian Government’s lack of experience delivering clinical services.

19.5 A wide-ranging review of Open Arms is needed

160. A range of issues affects Open Arms. Some of them were identified in response to the large number of Open Arms clients who died by suicide. We recognise that these issues are serious, as is the context in which they were raised. We also acknowledge those who shared their negative experiences in dealing with Open Arms.
161. We are concerned, too, about the structure of Open Arms. As we note earlier in this chapter, the Australian Government does not directly deliver clinical services to any other Australian population cohort. Efforts to expand access to Open Arms services and increase its service offering have been costly, and have affected its workforce and (potentially) the quality of the services themselves. This raises questions about whether it is an appropriate, effective and sustainable arrangement, and one that best meets the needs of members, veterans and their families.
162. We note that Open Arms is undertaking a number of reforms, including those that attempt to address issues identified in recent reviews. Some, like the move away from a contracted workforce and efforts to embed greater clinical capacity in Open Arms, are commendable. However, we cannot say with confidence what the broader outcomes of its reform program, including the new Model of Care, will be.
163. At the same time, we cannot say that an alternative model would be preferable. Instead, progressing an alternative model creates risks. It would mean more change, coming after the existing reform program, with the potential to create uncertainty, including among Open Arms's workforce. There is the risk that this will be used to consolidate funding, or reduce the quality and scope of services (funding sustainability, after all, was the reason DVA began its deep dive). A stretched labour market means there may be limited capacity – or willingness – among other providers in the sector to take on Open Arms services.
164. With this in mind, it is best to allow time to carry out reforms. Afterwards, an independent review could assess their impact, and recommend if and how Open Arms should provide services going forward.

Recommendation 75: Conduct an independent review of Open Arms and publish the report

The Australian Government should commission an independent review of Open Arms, to commence in 2027, following the implementation of the new Model of Care and led by a qualified entity outside of the Defence portfolio.

The scope of the review should be wide-ranging and it should examine:

- (a) how Open Arms is discharging its functions, including its compliance with clinical standards and its management of at-risk clients
- (b) issues that could affect Open Arms' ability to discharge its functions, including workforce, culture and funding
- (c) what functions Open Arms should perform within the wider network of services accessible to serving and ex-serving members
- (d) the appropriateness of Open Arms' delivery model, and whether another model is preferable.

The Australian Government should make the review's report public.

Endnotes

- 1 Exhibit S-01.050, Department of Veterans' Affairs, Response to Notice to Give, NTG-OPA-001, OPA.9999.0001.0002 at 0002 [1.2].
- 2 Exhibit S-01.050, Department of Veterans' Affairs, Response to Notice to Give, NTG-OPA-001, OPA.9999.0001.0002.
- 3 Exhibit S-01.049, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-163, DVA.9999.0154.0001 at 0003 [3.3].
- 4 Exhibit S-01.050, Department of Veterans' Affairs, Response to Notice to Give, NTG-OPA-001, OPA.9999.0001.0002.
- 5 Exhibit S-01.050, Department of Veterans' Affairs, Response to Notice to Give, NTG-OPA-001, OPA.9999.0001.0002.
- 6 Exhibit S-01.049, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-163, DVA.9999.0154.0001 at 0011 at [13.1].
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- 8 Exhibit S-01.050, Department of Veterans' Affairs, Response to Notice to Give, NTG-OPA-001 at 0007 [3.1].
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- 18 Exhibit F-05.012, Open Arms Quality Innovation Performance Accreditation Report, August 2022, DVA.5045.0001.0390 at 0505.
- 19 Transcript, Leanne Cameron, Hearing Block 7, 27 October 2022, p 54-5211 [20–22].
- 20 New South Wales Public Service Commission, *State of the NSW Public Sector Report*, 2019, pp 72–74 (Exhibit CC-01.096, DVS.6666.0001.2810). [https://www.psc.nsw.gov.au/assets/psc/documents/PSC_SOPSR2019_ACC.pdf]
- 21 Vietnam Veterans' Counselling Service National Advisory Committee, *Submission from the Veterans and Veterans Counselling Service National Advisory Committee to the Inquiry into Veterans' Affairs' Legislative Framework and Supporting Architecture for Compensation and Rehabilitation for Veterans*, June 2018.
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- 33 Exhibit F-05.011, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-047, DVA.9999.0060.0002 at 0064 [55.2].
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- 35 Exhibit F-05.011, Department of Veterans' Affairs, Response to Notice to Give, NTG-DVA-047, DVA.9999.0060.0002 at 0064 [55.3]-0065 [55.4], [57.1-57.3].
- 36 Exhibit F-05.013, Open Arms Deep Dive, DVA.5045.0002.0086 at 0088.
- 37 Exhibit F-05.013, Open Arms Deep Dive, DVA.5045.0002.0086 at 0094.
- 38 Exhibit F-05.013, Open Arms Deep Dive, DVA.5045.0002.0086 at 0094.
- 39 Transcript, Leonie Nowland, Hearing Block 12, 6 March 2024, p 88-8792 [22–23].
- 40 Transcript, Leonie Nowland, Hearing Block 12, 6 March 2024, p 88-8792 [39–40].
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- 47 Exhibit F-05.012, Open Arms Quality Innovation Performance Accreditation Report, August 2022, DVA.5045.0001.0390 at 0410, 0502.
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- 54 Francis Donovan, Submission, ANON-Z1E7-QXWC-A.
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- 56 Name withheld, Submission, ANON-Z1E7-Q16S-J.
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58 Exhibit 53-03.010, Hearing Block 7, Adverse event reviews, OPA.0003.0001.0541 at 0547.
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75 Exhibit 53-03.010, Hearing Block 7, Adverse event reviews, OPA.0003.0001.0541 at 0542.
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- 100 Exhibit F-05.012, Quality Innovation Performance Accreditation Report for Open Arms, DVA.5045.0001.0390 at 0396.
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20 Postvention

Summary

Each death by suicide is a tragedy that profoundly affects those left behind and those who witness the death or its aftermath. Postvention is the support offered to people affected by a suicide death.

Research indicates that an average of 135 people are affected by a single death by suicide, including family members and loved ones, colleagues, friends, support people and first responders. Research has also shown that the death of a loved one by suicide increases one's own risk of premature death, including by suicide.

In this chapter we:

- discuss the effects of suicide death on family, colleagues and first responders
- examine the postvention supports provided by the Australian Defence Force (ADF) and Department of Veterans' Affairs (DVA)
- discuss shortcomings in ADF and DVA postvention support and share the experiences of people who have been affected by Defence and veteran suicide and were not well supported.

We look at what the ADF should be doing to improve its response to suicide, including by adequately training commanding officers. We recommend that the ADF develop a postvention framework, with input from experts and those with lived experience. We stress the need for more research into postvention, and better evaluation of postvention policy and how it is put into practice in Defence and DVA.

While many people affected by Defence and veteran suicide shared their appreciation for the bereavement support provided by the ADF, some were also critical of how they were notified of a death, what they were told and what information they were not able to access. Many were critical of the fact that support was only offered to close family of serving and ex-serving ADF members who die by suicide, and also that it was not available to the families of reservists who die by suicide.

We examine DVA's postvention supports, including shortcomings due to the narrow definition of family, significant delays in responding to bereaved family members and limitations that arise due to DVA being a compensation-based organisation.

We recommend the expansion of specific postvention provisions, and a more collaborative approach to supporting bereaved families and the wider veteran community.

20.1 Introduction

1. 'Postvention' is a term specifically connected to suicide bereavement. It refers to:

[the] concerted response to, and provision of care for, people bereaved by suicide, including those impacted by the suicide of a family member, friend, or a person in their social network.¹
2. This chapter focuses on the postvention provided by Defence and DVA in the aftermath of a death by suicide. We discuss the importance of providing care for those exposed to suicide death, including family members, colleagues and first responders, and the ongoing negative effects of delayed or insufficient support.
3. Although postvention is offered in the wake of a death by suicide, it is nevertheless a necessary component of comprehensive suicide prevention.² Evidence suggests that those exposed to a death by suicide, including bereaved individuals, are at heightened risk of premature death, suicidality, trauma, psychiatric illness, substance use disorders, poor social outcomes and psychological distress.³
4. This is especially the case within tight-knit communities and those otherwise at risk – such as the military, whose members share close bonds and where the death of an individual is strongly felt, as this quote explains:

This ripple effect of suicide is particularly relevant for the close-knit military community which is highly structured in such a way that leaders of both small and large groups are acutely involved with – and often responsible for – the day-to-day activities of their soldiers, sailors, airmen, and marines.⁴
5. Defence and DVA have a responsibility to employ evidence-based, consistent, timely postvention as part of their duty of care to the wellbeing of members and their families. We believe that much more needs to be done to improve postvention support for serving and ex-serving ADF members and their families.
6. We recognise that it may never be possible to prevent every death by suicide, even though that should be the collective goal. For this reason, in addition to robust strategies for suicide prevention, there needs to be equally robust postvention to support and assist those bereaved by suicide.

20.2 The complex aftermath of death by suicide

7. Suicide 'ends the pain of one but brings new pain to those left behind'.⁵ With the study of postvention growing over the last 50 years, the impact of suicide and the necessity of survivor support is increasingly recognised:

The evidence is clear and overwhelming – and, sadly, not definitively recognized in the suicide prevention field – that exposure to the suicide of another person, particularly of a close intimate, elevates the risk of suicidal behaviour and

[death by suicide] in the person exposed. Additionally, exposure markedly increases the risk of numerous other deleterious mental health, relational, and social consequences.⁶

8. Different terms are used to describe a person who has lost someone to suicide. These include 'survivor', 'suicide-loss survivor', 'bereaved by suicide' and 'survivor of suicide loss'. These terms are most commonly associated with those who had a close relationship with the deceased.⁷
9. However, first responders, bystanders, witnesses, acquaintances and those who hear about a death by suicide can also be deeply affected. People from these groups may be referred to as the 'suicide exposed', 'suicide impacted' or 'those affected by suicide'.⁸

20.2.1 Suicide's ripple effect

10. Each death by suicide effects many people, often for a long time. As these suicide researchers put it:

The metaphor of a stone thrown into a lake reflects well the wide-reaching impact of suicide. It causes many ripples which turbulently affect the water's surface. The big challenge for effective postvention is ensuring that every survivor, from the close family members and friends to those indirectly exposed to suicide, can receive help and support they need.⁹

11. Research suggests that approximately 135 people are affected by a single suicide death.¹⁰ This includes an estimated five immediate family members, 15 extended family members, 20 friends, and 20 classmates or workmates.¹¹
12. In tight-knit communities such as the military, the number impacted can be much higher. The US Postvention Toolkit for a Military Suicide Loss has estimated that up to 6,000 sailors on a navy ship, 500 to 900 soldiers in an army battalion, and 300 to 500 aviators in an air force squadron may be impacted following a suicide.¹²
13. Not only is the effect of suicide widespread, it can also be enduring. In 2016, Suicide Prevention Australia published a study of a cohort of 3,220 people to better understand the impact of suicide. It found that affected people demonstrated high levels of long-term distress as a result of the loss, up to 58 years after the reported suicide death.¹³
14. A University of Manchester study found that of more than 7,000 participants who were bereaved or affected by suicide, 82% reported a major or moderate impact on their lives. This included a number of serious social adverse consequences, such as relationship breakdown, unemployment or financial problems, as well as poor or deteriorating physical and mental health.¹⁴

15. Further to this, recent studies have suggested that approximately 47% of serving members and 65% of ex-serving members have been exposed to at least one suicide.¹⁵ This means that the Defence community is a highly suicide-exposed population and many have been bereaved by suicide many times over. This takes an enormous toll on them and puts them at significant risk.

What can suicide bereavement look like?

16. While the loss of a loved one by any means is always significant and painful, people who lose a loved one to suicide may be prone to:
- preoccupation with finding explanations to make sense of the death
 - experiences of stigma and judgement from their community or social networks
 - feelings of shock, rejection, abandonment and anger towards the deceased over their perception that the deceased chose to leave them behind
 - feelings of guilt or shame for not preventing the death, or in reaction to any feeling of relief they might have
 - looking to attribute blame and responsibility, either towards themselves or to others
 - experiencing complex grief.
17. They are also at heightened risk of premature death, suicidality, trauma, psychiatric illness, substance use disorders, and psychological distress.¹⁶
18. Suicide-loss survivors may also have fewer of the protective factors that make it easier to cope, placing them at greater risk of worsening mental health. For example, people bereaved by suicide are less likely to accept social support, even when offered, and often report that people within their social circles do not know how to react. They are more likely to socially withdraw at a time when social support can be crucial.¹⁷ Furthermore, many people bereaved by suicide find it hard to access appropriate support.¹⁸
19. Professor Myfanwy Maple, the discipline lead for Social Work and Community Services in the Faculty of Medicine and Health at the University of New England as well as Deputy Chair of the National Suicide Prevention Research Fund, told us of the significant alienation survivors may experience as a result of suicide loss:

Almost every family member I've ever spoken to, or somebody that has been bereaved by suicide, will say that it's really hard to talk about. Often people will say sort of platitudes like, 'How are you today?' Somebody bereaved by suicide won't know 'Can I talk about how I'm really feeling about this person who has died, or just say I'm okay?' That increases that social isolation, increases the distress that somebody's feeling.¹⁹

20. Recent studies have pointed to experiences of 'post-traumatic growth' after experiencing the loss of a loved one to suicide.²⁰ Post-traumatic growth is defined as positive transformations that can occur in the domains of 'self-perception, interpersonal relations, and life philosophy ... as the result of one's struggle with a traumatic event'.²¹ While these changes do not lessen or invalidate the pain of suicide bereavement, the loss can exist alongside expansion in one's capacity of empathy for the suffering of others, a strengthening of family communication, appreciation of social supports, or awareness of one's own strengths.²²

Suicide loss has a tremendous impact on families

21. After a suicide, many families experience disrupted relationships, routines, functioning, finances, and roles and responsibilities of its members.²³ Family members are often closest to the deceased, and experience intensely distressing feelings such as rejection and shame, and report higher rates of mental health concerns.²⁴
22. For parents, the suicide death of a child can 'reverse the logic of life'. During their grief and shock, families may be overwhelmed with handling administrative processes, including organising the funeral, handling legal matters and working with the coroner.²⁵ Comprehensive and compassionate support is critical to support families grieving the loss of a loved one.

Suicide loss may cause intergenerational trauma for children and adolescents

23. A suicide in the family can be a very frightening and confusing event, with children sometimes feeling that they may have been to blame and feeling guilty.²⁶ When a parent dies by suicide, their children are at increased likelihood of future depression, suicidal ideation and self-harm behaviours.²⁷ Some parents who lose their partner to suicide find it difficult to balance the needs of their children while grieving their loss. For this reason, interventions following a death need to support the entire family unit. Specialised mental health counselling can reduce the developmental impact on young people.²⁸

Suicide death profoundly impacts staff, clinicians, first responders and health practitioners

24. Clinicians, first responders and health practitioners who work in proximity to suicide death and the suicide bereaved are at risk of vicarious trauma, feelings of guilt, perceived loss of competence, burnout, and hesitancy to deal with clients at high risk of suicide. This is a result of the stress and emotional toil associated with responding to suicide deaths.²⁹ Professionals who are exposed to many traumatic events and experiences of loss are at increased risk of adverse mental health outcomes and suicidality.³⁰

Suicide loss significantly effects colleagues, friends and communities

25. Research on the association between suicide bereavement and subsequent future suicide attempts by people who knew the deceased or responded to or cared for the deceased, has found that '[suicide] risk also applies to adults bereaved by peer suicide'.³¹
26. Research indicates that work colleagues exposed to suicide are 3.5 times more likely to experience suicidal behaviour than the general population.³² In this way, friends and colleagues, as well as family members, warrant support after a suicide, and 'employers should be aware of the impact of suicide bereavement on occupational functioning, and make adjustments to promote workplace mental health'.³³

Military populations may be particularly vulnerable post-suicide

27. Among military personnel, suicide exposure is associated with greater self-reported likelihood of a future suicide attempt, as well as suicidal planning and non-suicidal self-injury over the course of their life.³⁴ This may be due to a culture with strong peer connectedness; higher occupational exposure to trauma generally; the military culture of self-reliance and stoicism acting as a barrier to help-seeking; and higher instances of suicidal ideation in this cohort.³⁵

20.3 What is postvention?

28. Postvention is the support offered to people impacted by a suicide death, including family members, friends, colleagues and the wider community.
29. Postvention aims to:
 - mitigate adverse effects arising from an exposure to suicide and to assist in recovery
 - prevent future suicides, especially among those who are at high risk.³⁶
30. Postvention can be classified as kinds of support provided in the immediate term (during the crisis or acute phase), and those offered in the medium to long term (sometimes over months or years).³⁷
31. Postvention encompasses a broad range of interventions tailored according to need.³⁸ Services for the bereaved are divided into four categories, those being:
 - information, including leaflets, books, booklets, factsheets, posters and online information
 - assistance, including support services, support organising the funeral, legal services, helplines, and community and educational support
 - counselling, including peer support groups
 - psychotherapy, as a clinical intervention for those with complicated grief reactions or post-traumatic symptomatology.³⁹

32. Throughout the Royal Commission we heard that peer support was especially important and wanted by suicide survivors.⁴⁰ Peers are better able to establish connections of trust with those in need of support. Peer supporters draw on their shared experiences to provide empathetic understanding, information and advice.⁴¹ This is especially important in relation to suicide, where stigma and social withdrawal are major barriers to care.⁴²
33. Postvention activities also include conducting research, and monitoring and evaluating programs so they can be improved. Those with lived experience should be involved in designing programs and policies⁴³ to align services with the needs of end-users:
- Listening to survivors themselves and exploring their needs and experiences, as well as engaging them as active partners in research, should be the first step in establishing effective services.⁴⁴
34. The way suicide is communicated to a community is also an important aspect of postvention.⁴⁵ The media can assist in reducing the suicide rate, for example by presenting cases of positive coping; using language carefully to reduce sensationalism of suicide; and, when discussing suicide-related topics, listing crisis hotlines and organisations that offer support, including where to find different treatment options.⁴⁶ Mindframe has created best-practice guidelines for reporting and communicating about suicide.⁴⁷

20.4 Postvention in the ADF and DVA

35. The following sections critically evaluate ADF and DVA postvention programs.
36. As postvention activities and levels of support differ depending on the organisation, we analyse postvention support offered by:
- the ADF after the suicide of a serving member, for:
 - current members
 - the deceased's family
 - DVA after the suicide of a former serving member, for:
 - the deceased's family
 - the military community at large.

20.4.1 Postvention supports offered to ADF members

37. This section investigates the postvention support given to military personnel when there is a suicide of a current serving member.
38. We identify gaps in the current arrangements and note work underway to develop specific postvention guidelines.

The ADF's Critical Incident Mental Health Support framework does not constitute a postvention model

39. Currently, in the absence of a specific postvention framework, we understand that Defence follows the Critical Incident Mental Health Support (CIMHS) framework when responding to deaths by suicide or suspected suicide.
40. The CIMHS framework guides the early intervention support to be provided to members exposed to a critical incident or a potentially traumatising event.⁴⁸ According to Defence, CIMHS is a 'phased, flexible and scalable model which allows for a stepped care approach'.⁴⁹ We discuss this more fully in Chapter 15, Promoting health and wellbeing among ADF members.
41. We consider CIMHS to be inadequate as a postvention procedure because:
- it is a broad policy for responding to any critical incident or potentially traumatic event, rather than a specific framework designed for suicide postvention
 - it is designed to guide interventions in the immediate term, while postvention requires a longer-term strategy and plan of activities, though we note that CIMHS does provide for members to be referred to appropriate ongoing care
 - it mostly relies on proactive help seeking by those not directly exposed to the serious event, which is ineffective in a military environment where vulnerability is stigmatised and stoicism is the norm, and an active model of postvention would be more effective
 - from the evidence we have heard, it does not appear to be implemented consistently following deaths by suicide.
42. As such, we do not consider the protocols and responses provided under CIMHS to be an adequate postvention response.
43. CIMHS responses are intended to 'maintain or improve the mental health and wellbeing of Defence personnel impacted by a critical incident or potentially critical event and to assist commanders and managers meet their duty of care obligations in accordance with [the] *Work Health and Safety Act 2011*'.⁵⁰
44. CIMHS is used primarily for traumatic events that occur in the course of military operations. These include natural disasters, and other events that occur on deployment, such as explosions, motor vehicle accidents and lethal events.⁵¹ Defence defines a critical incident as 'a psychologically distressing event which is outside the range of usual human experience, and which has the potential to easily overcome a person's normal ability to cope with stress'.⁵²
45. CIMHS aims to provide initial intervention for people exposed to these events.⁵³ The majority of CIMHS responses are for firsthand victims of a trauma (such as those involved in a life-threatening event or accident), as well as witnesses and first

responders.⁵⁴ This is problematic in the context of suicide loss, as the trauma that results from a suicide death is often experienced indirectly within the community as a loss of attachment as well as grief, shock and distress.⁵⁵

46. Those directly exposed to a suicide death are at heightened risk of post-traumatic symptoms and may benefit from a protocol such as CIMHS. However, the majority of colleagues affected by a suicide death will not be direct witnesses, and therefore may not be identified by CIMHS as needing support.⁵⁶ They will nevertheless need supportive interventions to come to terms with the loss and buffer against the adverse effects of suicide bereavement, including suicidal thoughts and behaviours.⁵⁷
47. A CIMHS response is also not mandatory; command has discretion over whether a response will be initiated. A response may not be deemed necessary at all when a member dies by suicide in a location remote from their colleagues, or if no ADF member was directly exposed.⁵⁸
48. In terms of the need for longer-term support for the suicide bereaved, CIMHS is inadequate because involvement in a critical incident is not necessarily recorded on a member's medical record.⁵⁹ This prevents medical professionals from monitoring the long-term health of ADF members exposed to critical incidents.
49. In postvention, 'exposure' refers to those who know about a suicide or are affected directly or indirectly. This is estimated to be around 135 people per suicide death, but may be even higher.⁶⁰ CIMHS-only responses therefore miss many important features of a robust postvention process, which should be designed to support whole communities.⁶¹ As these suicide researchers stated:

[a]lthough suicide postvention includes principles of critical incident response and stress debriefing, it has a larger scope with a narrower focus. While critical incident response and critical incident debriefing are designed to support workplaces in managing the crisis phase of a workplace incident, suicide postvention is a long-term strategy that addresses the needs of a workplace as a system.⁶²

Members' experiences of the ADF response to member suicide

50. We received more than 40 submissions and witness accounts detailing significant distress, anger, grief and feelings of being let down by Defence following the suicide of a colleague. The majority of those we heard from received minimal or no support.⁶³ This strongly suggests that using CIMHS to guide responses to member deaths by suicide has not met members' needs and expectations.
51. One member told us he received no support after the suicide of a colleague, and coped by using alcohol:

[content warning] I was not offered any crisis counselling despite myself being sent to his room to investigate why he didn't show for guard or being there when

his corporal kicked the door in, that night my only counselling was a bottle of whiskey. They didn't even realise I was involved until I ended up having a seizure after almost drinking myself to death.⁶⁴

52. A similar experience of extreme distress and lack of support was reported by an anonymous Navy member:

No support was really given to anyone directly involved/affected until the platform returned to [redacted]. This was of no value to the members, myself included, as I posted off the day we returned, to proceed [to redacted] for a new position. The aftermath was one of the most difficult times of my life, to put it plainly. I almost lost my marriage, my job, my financial position and also me as a person.⁶⁵

53. Many described the unbearable distress of losing many friends and colleagues to suicide:⁶⁶

Unfortunately, I have been exposed to a number of suicide events within ADF. The most recent being in 2022, and this was the most traumatic for me. I gave everything to help and in the end I felt helpless. I felt lost that I could not do more, I felt let down by a system that is stretched and cannot afford the depth of time or quality of care to those in real need. I recall on an almost daily basis, identifying that person after their passing and the collection and careful packing of their belongings. The sensation of moving through a process and, compounded with my own struggles with mental health, feelings of a system turning on me. I would give many things for just one more word with that individual and the many others that I have had the terrible misfortune to have been affected by.⁶⁷

54. Former member Mr James Geercke spoke about losing colleagues by suicide during his time in service:

The first suicide was within a couple of weeks of me being there. I just thought at first this was probably an isolated incident and didn't think too much of it. Yes, it was very sad and it wasn't pleasant news, but I didn't think too much of it at the time. And then – yeah, then every year ... there was another suicide. So, these weren't isolated incidents but they were regular occurrences.⁶⁸

55. A large number of these submissions were from members who were first responders to suicide events that should, according to CIMHS policy, require a CIMHS response.⁶⁹ However, many spoke about receiving no support whatsoever.⁷⁰

[content warning] No support was ever provided at [redacted]. One day, I was required to attend the home of one of our technicians who did not arrive at work and was not answering phone calls. A group of 3 of us attended the home where I discovered his deceased body ... This was a huge shock for the unit as this member seemed confident and strong of mind and body.⁷¹

56. The lack of effective and tailored postvention is a significant oversight by Defence, given its obligation to safeguard the mental health of members and its commitment to suicide prevention.⁷² As attested by the National Mental Health Commission:

The death of a peer, close friend or family member [is] a risk factor that may trigger mental illness or suicidal behaviour ... Research also indicates that Defence personnel who serve alongside other members who have attempted or [died by] suicide are at higher risk of suicide. As such, postvention supports are a critical component of suicide prevention interventions.⁷³

57. For members not directly exposed to a suicide, the CIMHS framework considers it their responsibility to self-refer to mental health support on base.⁷⁴ This constitutes a passive model of postvention support, in which individuals are made aware of supports and must initiate support on their own terms.⁷⁵ As the author of this anonymous submission told us, this approach is next to useless in a culture where members are socialised to 'take it on the chin':

I learnt of his suicide through talking with another member from my training, who was in location with the member. No counselling was offered. One point that I would like to bring up is that there is no system in place to capture who might be affected by learning of such tragic news. It's left up to the member to find help, but a Defence member doesn't realise that these experiences take a toll on your resilience over time. You're taught to 'crack on', 'you can do it'.⁷⁶

58. Studies suggest that in environments of significant stigma, active postvention is significantly more effective.⁷⁷ Active postvention involves an outreach of support initiated proactively by the support service or organisation.
59. Active postvention is associated with greater psychosocial wellbeing, fewer work-related absences and greater, more timely engagement with psychological supports, which may improve outcomes overall.⁷⁸ Expert witnesses Professor Myfanwy Maple and Dr Karl Andriessen told us about the benefits of active postvention models:

Very often people bereaved by suicide are reluctant to seek help from others, whether it's social support or professional support, and making these resources available to them can also help to decrease the barriers on a short-term or on a long-term [basis] ... a proactive way of promoting help-seeking may certainly be beneficial for people bereaved by suicide, so that they do not have to find out where help might be available on their own alone, because that's very often how people feel after a suicide.⁷⁹

60. Members talked about the benefits of receiving active care following the suicide death of a colleague. Mr John Armfield was a serving Navy clearance diver at the time of his serving brother's death by suicide. He told us that on returning to work at the Royal Australian Navy Diving School, his officer in charge felt a duty of care towards him and required him to engage with a doctor, who referred him to a psychologist. Mr Armfield told us he expected 'nothing less [under] the circumstances' and that at the time it had been 'beneficial'.⁸⁰

61. Mr Armfield was grateful that the support he received was ‘conducted very discreetly’. This was important as, in his words, ‘in that environment, it wasn’t a place you openly talked about mental health’.⁸¹ Mr Armfield stated that it was due to this psychological care that he was ‘able to move forward ... rapidly’ being ‘promoted to leading seaman’ within one year.⁸²
62. However, in a number of submissions, members described being actively discouraged from seeking help, fearing that disclosing their struggles would impact their career, and experiencing alienation and bullying by peers when they were open about mental ill health.⁸³ Some submissions spoke about the lack of empathy and judgemental attitudes of leaders expressed in highly inappropriate language referring to those who had attempted or died by suicide.⁸⁴ One person described to us in a submission:
- [content warning] There was a day an individual who I managed took his own life. When I informed my director, her comment was ‘About time he took his own life!’ I was devastated and I had no words. I had two friends console me after a tragic loss to the department.⁸⁵
63. The weight of this lived-experience evidence (with the many more stories we have heard and not reported here) suggests that a culture of stigma still pervades the ADF. Relying on the passive CIMHS model of postvention for the majority of ADF members exposed to suicide is entirely inappropriate. Active postvention encompassing a more proactive approach is needed, as well as a range of actions to normalise help-seeking.
64. It may not only be the proactive component of postvention support that makes it more effective, but also its delivery as a matter of course to whole groups of members. We were told in evidence by Dr Anthony Pisani, Associate Professor of Psychiatry at the University of Rochester Center for the Study and Prevention of Suicide, about very positive results obtained from network-informed suicide prevention. These are strategies that intentionally work with the properties of the group rather than characteristics of individuals.⁸⁶
65. While Dr Pisani was not speaking directly about postvention, his work with colleague Dr Peter Wyman with groups of military members in the Wingman Connect program brings out hidden strengths and helps create a culture where protective factors are present. Together, they have been effective in reducing suicidality and depression.
66. We believe that network-informed postvention could be similarly effective, not only in reducing stigma around the grief and mental health effects of suicide exposure, but also in promoting social bonds and positive behaviours such as talking with a trusted friend or seeking help from a professional.

CIMHS is not implemented consistently

67. Across a 20-year period only 380 CIMHS responses have occurred, an average of 19 each year.⁸⁷ This is a surprisingly small number, given that CIMHS responses are designed to be initiated for all life-threatening military events with the potential to affect members’ wellbeing, not just deaths by suicide.⁸⁸ Although CIMHS policy can and does

support some personnel, according to Colonel Neanne Bennett, a 'policy is only as good as it is actually implemented'.⁸⁹ We agree, and are concerned about the overall usefulness of the current CIMHS framework and the consistency of its application.

68. One particular concern is that CIMHS is not applied consistently following deaths by suicide of serving members. It is not entirely clear why, although this could come down to the definition of a 'critical incident'. It could be because command has discretion about whether or not a CIMHS response is initiated.
69. We find that some elements of the CIMHS are ambiguous, particularly with respect to who ought to be included in a CIMHS response in the aftermath of a death by suicide or suspected suicide.⁹⁰
70. We understand that commanders do not receive training in how to deliver postvention.⁹¹ As a result, they may be unaware of the impact of suicide on a community, including how widespread, significant and long-lasting it can be. They therefore may not regard suicide as 'critical enough' or see the short- and long-term risks of not providing support to members affected less directly.⁹²
71. As a result, support provided following a death by suicide essentially depends on what command deems necessary, without reference to any postvention-specific expertise.

Postvention support needs to be provided over the long term

72. A CIMHS response can include follow-up support for up to six months after the event. However, robust postvention involves a longer-term 'reconstruction phase' that may take considerably more time.⁹³ Features of a long-term postvention approach consider issues of honouring, recognition, transition to suicide-prevention activities, and allowing space for the 'oscillating experiences of grief'. CIMHS makes no mention of these features in its policy, so there is no provision for this essential dimension of a postvention response.⁹⁴

20.4.2 Developing postvention guidelines

73. Since mid-2023, the ADF has been developing postvention guidelines to expand the current CIMHS approach.
74. As at June 2024, ADF has developed a draft that is under consultation across Defence.⁹⁵ We understand the proposed guidelines will support commanders to respond to a suicide death regardless of whether a CIMHS response has been initiated. We hope the ADF considers the feedback offered during the consultation process and seeks advice from postvention experts.
75. Brigadier Caitlin Langford, Director General of the Mental Health and Wellbeing Branch, told us that postvention responses extended beyond the scope of what is offered under CIMHS and remain to be fully developed within Defence:

Postvention initiatives is something I sense there is an opportunity to be more curious about. Understanding that postvention is not necessarily ... a critical incident response ... so it's understanding what are some of the other resources and processes to support recovery of people after an incident [of suicide]. I would like to look into that further, but at the moment ... we're driving to that and that's a goal.⁹⁶

76. While developing postvention guidelines and 'being curious' about initiatives separate from CIMHS might be positive steps, we are concerned that specific organisational and structural features of the ADF may present barriers to implementing effective postvention. Barriers that need to be addressed include:

- stigma around perceived vulnerability
- leadership attitudes towards suicide and suicide behaviours
- known structural and cultural barriers to help-seeking generally
- workforce shortfalls leading to exaggerated operational tempo for deployable members and little choice in the posting cycle
- the current reliance on self-referral
- command discretion regarding the implementation of a response.

77. A postvention strategy fit for purpose within a military context should include:

- a model of active postvention assisted by a systematic process of identifying those at risk following a death by suicide
- active support to members at the base/platoon/ship level, not only those understood to be directly involved with the death
- adequate training and supervision of commanders and health service providers offering postvention support
- more research into postvention in military contexts, and better surveillance, evaluation and monitoring of postvention responses
- responses in the immediate term as well as medium- and longer-term supports.

Good postvention requires adequate training, supervision and resources

78. We have seen no evidence of any additional training in postvention for commanders or other professionals involved in postvention as part of the current draft guidelines. To effectively implement postvention protocols, Defence must, according to postvention specialists, 'ensure that first responders receive specialised training to be able to interact accordingly'.⁹⁷ There is need for more appropriate postvention training and support for commanders and service providers in the ADF.

Good postvention requires research, as well as monitoring and evaluation of activities

79. While it is well established that being exposed to suicide and experiencing suicide bereavement can significantly affect serving members, there is limited research on how to improve postvention outcomes in certain settings, particularly in the ADF.⁹⁸ In implementing postvention protocols within Defence, greater research into suicide bereavement and exposure of peers is needed. This will inform evidence-based resources for colleagues and close peers affected by the suicide death of a member.
80. Furthermore, monitoring, evaluation and reflection activities should take place to ensure that postvention practices are meeting their intended goals and responding to the needs of serving members exposed to suicide.⁹⁹
81. Defence has stated that as its suicide postvention process advances (including its draft postvention guidelines), this process will be included in future continuous improvement framework evaluation cycles.¹⁰⁰ This will allow the ADF to build its understanding about suicide-related grief and the efficacy of its interventions.

Recommendation 76: Develop a postvention framework with experts and those with lived experience of suicide bereavement

The Australian Defence Force should develop a postvention framework that must be implemented following a serving member's death by suicide (or suspected suicide) for the purposes of supporting the member's family members and colleagues, as well as first responders. It should involve:

- (a) collaborating with and seeking input from peak postvention organisations and those with lived experience of suicide bereavement
- (b) developing communication materials and training modules for commanders and key decision-makers about trauma-informed postvention support for Defence personnel
- (c) the use of a systematic process for identifying and referring those at highest risk following a suicide death
- (d) consideration of the unique circumstances of each posting or cultural circumstances of the bereaved
- (e) greater surveillance and evaluation of the broader impact of suicide on personnel and their functioning for the purposes of improving interventions.

20.5 Postvention support offered to ADF families

82. This section discusses the postvention support the ADF provides to family members of a serving member who has died by suicide. After analysing Defence evidence, testimonies of witnesses and submissions, we conclude that while the current bereavement model works well as a standard approach to handling deaths in service (such as that offered by CIMHS), families would benefit from an approach more tailored to suicide grief.
83. The following section presents Defence's current bereavement support model and the evidence that led us to conclude that is not currently well tailored to those bereaved by suicide.

20.5.1 The ADF bereavement support model

84. When a serving member dies, regardless of the cause of death, their family receives assistance through Defence Member and Family Support (DMFS) and a bereavement support team.
85. When a serving member dies, DMFS forms a bereavement support team, consisting of a Defence social worker and military support officer.¹⁰¹ The role of the team is to:
- provide practical support related to administrative tasks, planning the funeral and processing Defence entitlements
 - assess the family's needs and provide practical and emotional support to assist them with their grief and loss
 - manage the impact of Defence issues relating to a service death, including political and media interest
 - transition the family from Defence supports to non-Defence networks, community resources and tailored services, including those provided by Open Arms, a free counselling service run by DVA.¹⁰²
86. The DMFS bereavement support team does not provide bereavement counselling. A Defence member's immediate family members will usually be referred to Open Arms.¹⁰³
87. In response to the death of a Defence member by suicide, DMFS bereavement support is provided to the member's:
- spouse or Defence-recognised partner
 - parents, if the member is single
 - Defence-recognised dependants, or relatives for whom the Defence member has primary responsibility.

88. DMFS bereavement support is not provided to the member's:
- partner, if that partner is not recognised by Defence
 - extended family members
 - siblings.¹⁰⁴
89. A close friend of a member who has died by suicide may apply for Defence funding for bereavement counselling provided by an approved and accredited psychiatrist or psychologist. They can receive initial support of up to six sessions, and must provide justification for further counselling support if needed.¹⁰⁵
90. The aim of the bereavement support team is to provide close friends and family members with the resources, skills and capabilities to engage with support networks, DVA and community services once the support period has ended.¹⁰⁶

Appreciation for bereavement support

91. We heard evidence from family members who found the ADF bereavement support model helpful in organising the funeral and handling practical and administrative tasks.¹⁰⁷ Mr Peter Jenkins spoke positively of the support he and his wife received from their deceased son's unit. He appreciated how the funeral was conducted and the ongoing contact from a Defence chaplain, saying:

The Defence personnel that assisted us when Shaun died were amazing, they were all really, really good. I couldn't say a bad word against any of them. And Padre still has contact with us every year at about the time of Shaun's passing. And in fact, I spoke to him only last week. So, from that perspective, the Padre has been brilliant and, as I said, the Defence personnel that assisted with the preparation of Shaun's funeral and everything were really, really good.¹⁰⁸

92. Ms Robyn Halloran and Mr John Halloran told us that the empathy and respect they received from the Army mattered significantly after the death of their son:

We were sincerely welcomed into 5RAR because of Tom, and we do feel like family with them. And ... it's a culture that we've never seen before, and it's a healthy culture that they have. The amount of empathy that they have for each other's soldiers is incredible. And Tom's funeral was done by 5RAR at 6RAR down in Brisbane for us. And, again, it was when the floods were on, and the rain, you've never seen anything like it, and there were a hundred soldiers standing out in that rain and they carried him onto ... the gun carriage, and there was a salute, and it was done in pouring rain and not one person flinched. And it [was] – moving, and it's something we will never see in our lifetime again, or feel in our lifetime again.¹⁰⁹

93. Despite these positive experiences, our analysis has identified issues with the ADF bereavement support model, including:

- the need for greater sensitivity and consistency in communications with loved ones and colleagues
- the need for better support specific to suicide bereavement
- the lack of support for extended family members, and reservists
- the need for the ADF to be transparent about 'lessons learnt' and the actions it will take to prevent future suicides
- the lack of culturally tailored postvention for First Nations and culturally and linguistically diverse families.

20.5.2 Sensitivity around notification

94. Defence aims to notify families of a casualty promptly and compassionately.¹¹⁰ Notification teams comprise a Defence member of at least 04 rank (Lieutenant Commander, Major or Squadron Leader), preferably from the deceased Defence member's unit, as well as a chaplain. Defence has a mandatory requirement to notify the member's primary emergency contact of the death or serious injury of a member, and to then notify the member's next of kin.¹¹¹

95. Veteran Family Advocate Commissioner, Ms Gwen Cherne, spoke about her distress at being told about her serving husband's death by suicide in public by a neighbour, over the telephone:¹¹²

[I]t was one of the most dehumanising experiences of my life to be in the middle of a shopping centre and find out that my husband was dead. So while we don't always appreciate why some of the Defence processes are in place, [the formal visit from a padre, member of Defence and police], I think, we should really try to respect and, if not, at least ensure the family member is in their own home with support around them before they are told.¹¹³

96. Commissioner Cherne emphasised the importance of the Defence notification process that 'tries to honour the family's right to dignity in perhaps the worst moment of their life'.¹¹⁴

97. Ms and Mr Halloran told us their experience of knowing that their son had died, yet having to wait for hours to learn what had actually happened.¹¹⁵ They said that while the Defence notification process aims to be respectful by informing the family in person at their doorstep, circumstances often demand flexibility on this rule:

we've been told it is what happens when someone dies in service, and then you are officially informed by somebody that comes to your front door, and it's very dignified and I get it, and ... the people that came were absolutely wonderful people. However, we already knew and we had been sitting there for 3.5 hours trying to put it together. I mean, you know, I can't tell you what that felt like sitting there. So, what we think is there is not a right way to do this every time.

If someone passes away in service and they don't know, and the first thing you hear is someone at the front door, then I get it. That makes sense. But to invoke that silence in this situation didn't make any sense. It was 3.5 hours of sitting there trying to get a story, trying to work out what happened. And so when they came, we said, 'This is – we appreciate you coming, but we know.' And they said, 'Yeah, we know you know.' Everyone's so embarrassed ...

... [there needs to be the] ability for someone to make a decision and say 'they already know. Just speak to them, talk to them.'¹¹⁶

20.5.3 Need for greater support specific to suicide bereavement

98. To assist families with the unique devastation that is suicide bereavement, the bereavement support model should have a stronger suicide-specific focus to guide processes and protocols when a member has died by suicide.
99. DMFS recently updated its information for families, to include information relevant to those who have lost a family member to suicide.¹¹⁷ This includes two factsheets that outline what emotions and thoughts to expect after a suicide, as well as helplines, support services (including StandBy, Postvention Australia, Thirrili and Anglicare), and leaflets from StandBy on suicide grief.¹¹⁸ The ADF Bereavement Guide has also been updated with a section on 'additional support available for people bereaved by suicide'.¹¹⁹
100. While these are positive steps, families could benefit from more comprehensive postvention resources, and connection to longer-term psychosocial care including peer support and child-specific support.
101. In updating its postvention resources for bereaved families, the ADF should:
 - collaborate with people who have lived experience
 - create a comprehensive library of bereavement resources on its website
 - provide information on how to access coronial inquests and engage with freedom-of-information processes.

Improving postvention through collaboration with people who have lived experience of suicide bereavement

102. Defence needs to better understand the needs of families bereaved by suicide. There is a lack of Australian academic literature exploring the experiences of military families who have lost a family member to suicide.¹²⁰ The most recent review of bereavement and family support offered by DMFS was conducted by the Auditor-General in 2012.¹²¹ However, the review had little information on the lived experience of families specifically in the aftermath of suicide.

103. Defence must engage with families bereaved by suicide to identify pathways to provide support and address gaps in care, as well as unmet needs.¹²² Defence says it ‘plans to undertake consultation with several Defence families bereaved by suicide’.¹²³ We are aware this was due to be completed in March 2024.

Addressing the need of the bereaved for explanations

104. Many people who experience suicide bereavement have a strong need for answers and to understand why their loved one took their life. They often look for explanations that will help them make sense of the death.¹²⁴ Suicide death generates many questions, and it is often highly distressing for survivors not to have answers. Typically, this results in a family’s strong desire to find out as much information about their loved one’s final moments as possible, including the who, what, where, when and how of the death.¹²⁵

105. Ruminating on the manner of death and these questions distinguishes suicide bereavement from other forms of loss, and can impede survivors’ grieving:

Many bereaved meticulously investigate their own behaviour and the behaviour of the deceased to find internal (psychological or biological) and/or external explanations for the suicide. It is important for the suicide survivors to know whether the suicide was a personal, wilful decision or an act that was driven by particular problems, mental illness or other difficult circumstances.¹²⁶

106. The need of family members to obtain as much information as possible about their loved one’s final days and death is clear from the experiences of families who engaged with us.¹²⁷

107. Ms Jan Williams, whose son took his life, wrote about how it felt for her:

Accidental death takes the lives of so many and whilst it would be difficult for a parent to cope with, it is a closed case, but suicide deaths often leave more questions than answers: Why did our boy feel he had no other option? He was surrounded by supposed mates – where were they when he needed them? Why, when he had a minor injury, was he outcast as worthless, a malingerer and shamed? Why was there nowhere for him to turn for help – counselling, psychology support ... at that time, as implanted in his psyche by the Army, would [it] have been an admission of failure?

I want you to know that I have no answers to these questions: How do I cope with looking into the eyes of my husband, daughter, and son year after year on the anniversary of his death; occasions of family celebrations, and see the sadness and desolation and grief this has been bestowed on us? How do I console them when I am feeling as [bad] or worse than them? Will this ever get easier to cope with? Time does not heal – we do not forget, and each day is another day without him.¹²⁸

108. While it is not always possible to fully answer the ‘why’, Defence needs to be more sensitive when interacting with families, and forthcoming with information and details, when they can be. DMFS and Defence staff who interact with families after a suicide death need to be well trained in the specifics of the task, and able to provide (where possible) avenues to assist families to find the information they seek. This can be done, for example, by accessing records or providing information about coronial inquests or other investigations.

109. In the words of one assistance program for people facing suicide loss:

While we may never get the exact answers we seek, understanding more around this subject matter can often help survivors of loss as they heal through the grieving process.¹²⁹

Information and records

110. Defence should help families to access records or information where doing so is reasonable, by providing details about freedom-of-information or similar processes. Currently, DMFS policy documents and bereavement pamphlets do not include this information.

111. For example, Ms Alexandra Bailey, who lost her sister (who was a former member of the Royal Australian Navy) to suicide, told us how important it is to have information about a loved one:

I mean, obviously, as a grieving family who is trying to piece things together, we would like to have had a lot more information. I feel that we deserve a lot more information. It’s a very difficult thing to be given a few documents and have to try to piece that together.¹³⁰

112. Mr Peter Jenkins also wished Defence had proactively contacted him after the suicide of his son, to say ‘here is the information we have’:

As parents, and I would imagine it would be exactly the same if it was a wife or partner, as parents all we wanted was answers as to why we had lost a son.¹³¹

113. There is often a tension between Defence’s ability and willingness to provide answers and the family’s need for them, especially when information is confidential. In any case, although records are unlikely to fully answer the ‘why’ question, assisting the bereaved to obtain information improves transparency and increases the family’s trust in Defence.¹³²

114. We heard from families who felt obstructed from obtaining documents or personal effects, and when they did receive material it was heavily redacted or truncated, giving the impression that Defence was not willing to be forthcoming. This exacerbates the family’s grief and the violation of trust they feel, as well as blame, distress and anger.¹³³

115. Mr John Armfield told us he only became aware of an internal inquiry report into his brother's death by suicide 12 years later. He had to fight to get a copy of the report.¹³⁴ Mr Armfield found this to be a complete betrayal by the organisation in which he had placed his trust:

I was shocked that us, as the family, were required to seek ADF approval to access the Inquiry Report that had already been released to other parties.¹³⁵

116. After months of trying to get a copy, ADF headquarters told Mr Armfield that he would get the report via Australia Post. When he received the report at the post office its contents devastated him. He couldn't understand why the organisation had had no compassion for how the report might affect him, and offered him no support.¹³⁶

I hadn't expected [the report] to be insensitive and disrespectful, nor to identify any failings in the treatment of my brother ... I was in tears at the total disdain and commentary regarding my brother by the SMO [senior medical officer] ... the content of the Inquiry Report was shocking to me. What was equally shocking to me is that the ADF would send such an Inquiry Report to me in the mail rather than hand-delivering it to me within the confines of an ADF safe space with appropriate supports in place.¹³⁷

It broke me. It literally – the content of that report ...

...

I was sitting in my car, broken. I'd loyally served my nation, I'd recruited [others] for my nation and this is how they were giving me the report on my little brother's death.¹³⁸

117. Dr Nikki Jamieson also spoke to her distress in being given heavily redacted documents after the suicide of her son, a private in the Army:

The biggest lack of transparency I'm finding is being through the Freedom of Information process and the redacted information. Ninety per cent of it was blacked out. That's no use to anybody. How am I ever going to be in a position to understand fairly and equitably what went on in my son's case when most of the information is redacted? I suspect that's obviously to protect members in Defence or whatever, but fundamentally I don't have a civilian process of natural justice, it's not fair and equitable for me because I don't have all the evidence there, so there's a lack of transparency.¹³⁹

118. Ms Madonna Palmer wrote in her submission about having to hassle Defence to get the information she needed following the death by suicide of her son:

I had to constantly chase them for information. Information about Damien's death was not forthcoming. It seemed that the more I questioned them, the less information they provided. I had to request a copy of Damien's autopsy report. The investigation report of the Military Police was heavily redacted, to the point that it was almost a useless report.¹⁴⁰

119. Recommendation 10 of our *Interim Report* states that the Australian Government must ‘engage with serving and ex-serving Australian Defence Force (ADF) members and their families’ by co-designing ‘information to raise the awareness of redaction and how it might apply to information provided to applicants seeking information from Defence or the Department of Veterans’ Affairs under all information access request mechanisms’.¹⁴¹ This is especially important in the context of suicide death and must be upheld in Defence’s bereavement support policy.
120. When medical records and other documents requested by a family cannot be provided in a reasonable timeframe, or are heavily redacted for privacy or security reasons, Defence staff should explain why. Additionally, Defence should offer families emotional care when providing these documents, given they may contain distressing content.
121. One anonymous author of a submission suggested that an appointed officer should assist the family to obtain information:

I think it would be very helpful if a family liaison officer be appointed to the family of a deceased member or veteran to assist with obtaining all relevant information from the various government agencies.¹⁴²

20.5.4 Connection to longer-term bereavement supports

122. The DMFS bereavement support team is responsible for providing emotional and practical support for up to 12 months after the death of a serving member.
123. Over this period, DMFS aims to transition families to community supports and DVA. Successful separation from Defence supports is seen as a quality indicator of the DMFS bereavement model.¹⁴³ However, families we heard from spoke of feeling cut off when they stopped receiving support, and struggled to access longer-term suicide bereavement support.¹⁴⁴
124. Families of serving members who have died by suicide need better access to specialised postvention supports, including peer support from other military families who have experienced suicide bereavement, and support services for children.¹⁴⁵ Families of ex-serving members who die by suicide also need bereavement support, including peer support and support for children.¹⁴⁶ We discuss this further in section 20.6.4.

20.5.5 Some people need postvention support but are not eligible for it

125. DMFS bereavement support is typically not provided to families of Defence members categorised as SERCAT (Service Category) 2 to 5; in other words, those who serve in the reserve forces.¹⁴⁷ Under certain conditions, reservists' families may be eligible for a Commonwealth-funded funeral of up to \$14,000.¹⁴⁸ These include only those reservists who:
- were on continuous full-time service (SERVOP C)
 - were in training
 - were attending a parade or bivouac
 - died due to injuries suffered or illness contracted while serving
 - had been on overseas operational deployment in the previous 12 months
 - were of a high enough rank, such as two-star, or had received the Victoria Cross.¹⁴⁹
126. Although the majority of families of reserve members are not eligible for Defence bereavement support, they may reach out to the Defence Member and Family Helpline (DMFH).¹⁵⁰ The helpline may provide 'referral to DVA, Open Arms and community-based support'.¹⁵¹ Any kind of postvention support from Defence for reservist families depends on their awareness of the DMFH, as the helpline is not active in its outreach.
127. If the ADF is serious about its commitment to the lifetime wellbeing of members and their families, all members of the ADF and their families – regardless of how long the member served, when they served, where they served or in what capacity they served – should have access to a standard of care that supports their wellbeing.¹⁵² A more proactive outreach approach for reservist families could improve family wellbeing by connecting families to adequate care in a more timely manner.
128. This is currently hindered by the fact that Defence does not have real-time visibility of deaths by suicide for ex-serving members or reserve members who are not regularly parading.¹⁵³ Improving visibility of suicide deaths of reservists would have additional benefits beyond being able to offer postvention outreach to their families. This includes supporting more holistic collection of suicide data and improved understanding of why members die by suicide. This information would in turn inform the development of more effective supportive interventions.
129. We discuss the need for better suicide surveillance in Chapter 29, Use of data and research by Defence and DVA.

20.5.6 Postvention support needs to be culturally sensitive

130. Defence needs to be culturally sensitive and appropriate in its postvention supports. Warrant Officer Class 1 Kenneth Nelliman told us that Defence needs to understand ‘who [it is] actually speaking to, or where that soldier actually comes from’ so that, following a death by suicide, Defence can operate in a procedurally and culturally sensitive way.¹⁵⁴ It is important for families to have the opportunity to express what is culturally appropriate for them, and to be able to choose an appropriate person within Defence to inform them in the event of a death.¹⁵⁵

131. Various factors must be considered before initiating a conversation with culturally and linguistically diverse families and communities following a suicide death. This includes understanding community conceptions of suicide and whether community members experience heightened risk of suicide. Other considerations include cultural taboos around suicide; stigma associated with mental ill health; protocols for discussing sensitive subjects; traditional cultural treatments for mental ill health; intergenerational trauma and impacts of racism and discrimination; and concerns around confidentiality.¹⁵⁶

132. Professor Helen Milroy AM, Professor of Child and Adolescent Psychiatry at Perth Children’s Hospital and University of Western Australia, and Chair of Gayaa Dhuwi (Proud Spirit) Australia, gave evidence on the different attachment or kinship systems seen in First Nations communities and how they compared with Western models of family. Aboriginal and Torres Strait Islander experiences and definitions of family, combined with Defence’s limits to postvention support, might mean close family members need support and cannot access it. As Professor Milroy told us:

Kinship models are a much broader attachment model, and relationships are one step closer than what you would have in a western perspective on family structure. If you looked at my family ... you would look at my brothers and sisters, all of their children and my children would be considered brothers and sisters, not cousins, and so the relationship is meant to be closer ... I would be considered a mother to my sisters’ or brothers’ children, and I would take on that role as mother, not as auntie.¹⁵⁷ It means that relationships are closer, but it also means that if you have losses, the losses are greater. So, losing an auntie is like losing your mother, it’s that sort of depth of grief.¹⁵⁸

133. Extended family members, siblings, and partners who have not been recognised by Defence are not eligible for DMFS bereavement support.¹⁵⁹ For First Nations families, this is especially detrimental, given their broader conceptions of close kin. Regional Indigenous Liaison Officer Ms Lee Smallwood told us of the lack of support available for First Nations family members following a suicide:

In my experience, when a Defence suicide occurs, parents and extended family often do not know that their child and family member had been experiencing suicidal thoughts. Defence should work closer with families, and not just spouses, to ensure that the member has additional layers of support ...¹⁶⁰

134. In his statement, Warrant Officer Nelliman said that Defence also needed policy guidance on appropriate leave entitlements for First Nations members to attend family funerals, sorry business or ceremony:

If a soldier needs to attend a cultural funeral or sorry business for a relative who is not an immediate family member, but family, there should be clarity for a commander to feel confident to release the Indigenous soldier to attend.¹⁶¹

135. Defence personnel tasked with family liaison following a death by suicide must be appropriately trained and skilled at handling these matters with great sensitivity and respect.

20.6 Postvention supports provided by DVA

136. This section explores the postvention support provided by DVA to ex-serving members experiencing suicide bereavement, and to the families of ex-serving members who have died by suicide. From the evidence we have heard, we are concerned with several aspects of DVA's postvention support, including:

- there is no DVA-wide postvention protocol
- postvention within DVA is based on legislated eligibility, meaning:
 - access is limited and difficult
 - it often comes too late
- many families are 'invisible' to DVA for the purposes of receiving postvention
- postvention delivery is not collaborative.

137. In Chapter 24, Empowering veterans to thrive, we discuss whether DVA is doing enough to support the wellbeing of veterans and we recommend a new agency focused solely on the wellbeing of veterans, not just DVA clients and claimants. Such an agency would play an important role in postvention support.

20.6.1 What does DVA postvention look like?

138. Issues with DVA postvention support begin with the fact that DVA simply does not have visibility of the majority of veterans who are not DVA clients.¹⁶² This has many implications, especially in terms of postvention. If DVA is to improve its postvention capabilities, it needs to get a clearer view of veterans and their families more generally, or alternatively, make veteran families aware of the services available to them.
139. We have also been told that DVA does not have an organisation-wide practice for providing postvention support to families of ex-serving ADF members who have died by suicide.¹⁶³ However, we have been informed that DVA is developing postvention protocols to support these families.¹⁶⁴ These protocols will be implemented after the Royal Commission has finished.

140. DVA administers a variety of departmental processes when it is notified of the death of a veteran. These processes are outlined in the DVA Bereavement Support Manual and the DVA Service Coordination Manual. These protocols primarily relate to dependants of veterans who were clients of DVA or Open Arms prior to their death.¹⁶⁵
141. DVA bereavement support for dependants of ex-serving members includes financial compensation and various packages under the three DVA Acts: the *Military Rehabilitation and Compensation Act 2004* (Cth) (the MRCA), *Veterans' Entitlements Act 1986* (Cth) (the VEA), and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (Cth) (the DRCA). Depending on the circumstances, these supports may include:
- various categories of bereavement payment (paid to the surviving partner in a couple)¹⁶⁶
 - funeral benefits¹⁶⁷
 - body transportation costs¹⁶⁸
 - a Widow's/Widower's Pension or Orphan's Pension (available for the partner or children of veterans with a disability pension)¹⁶⁹
 - the Acute Support Package¹⁷⁰ which, subject to eligibility, provides 'funding for practical assistance and wellbeing support as an extension to existing DVA services and entitlements'.¹⁷¹

20.6.2 DVA as a compensation-based organisation limits its support

142. DVA limits its support to those who were wholly or partially financially dependent on the ex-serving member at the time of their death, and only in the instance where the death is considered to have resulted from the member's service. As such it does not always provide postvention based on genuine need.¹⁷² As one submission author told us:

DVA is, and always will be, inherently encumbered by its remit ... If access to DVA's services or benefits is denied, that individual or family receives no further contact from DVA, and often, no referral to any other support service. If lucky, they will be discovered by Legacy or the RSL, but we know full well from our cases and from the statistics on family violence and suicide that many do not.¹⁷³

DVA's definition of family is too limited

143. Under both the DRCA and the MRCA, 'dependants' of an ex-serving member may be their partner, parents, step-parents, grandparents, children, step-children, grandchildren, brothers, sisters, half-brothers and half-sisters, but only if these family members were 'dependent for economic support' on the ex-serving member prior to their death.¹⁷⁴

144. In this way, although DVA has primary and legislated responsibility for veterans' compensation and rehabilitation, it has no legislative obligation to provide postvention support to family members outside of this definition under the VEA, MRCA and DRCA.¹⁷⁵ Support following a suicide death is only founded on providing compensation for 'any financial loss suffered by the dependant as a result of the member's death'.¹⁷⁶
145. This approach is exclusionary and ultimately harmful, which is clear from the experiences of families left with no assistance due to being ineligible for support under the rigid definition.¹⁷⁷ One member told us of his ex-wife's suicide and the effect on him, their children and his former parents-in-law, and the lack of support offered:

In retrospect and due to this Royal Commission, I've only just thought that her family and my daughter didn't receive any offers of counselling or a list of government or non-government agencies that they could communicate with for support ... My daughter suffered in relative silence for several years and still suffers of course ... For myself, the feelings of guilt, grief, blame etc. over the failed marriage exacerbated greatly due to the suicide and I contacted [Open Arms] after a few months asking for help. My then relationship ended soon after due to my own behaviour and more alcohol consumption after the suicide ... [Her] parents who are now in their 80s aren't as well informed [and do not] have that support available, which I believe would've been a huge help so they could better cope with their grief and better understand suicide and its effects on family and friends.¹⁷⁸

146. Ms Julie-Ann Finney, who lost her son to suicide nearly two years after he was medically discharged from the Navy, told us that despite being his mother, she was not listed as his 'beneficiary' and therefore received no respect or support. She reported feeling like a 'no one' in the eyes of the bureaucracy.¹⁷⁹
147. Mr John Armfield spoke about his sister, whose 'health has deteriorated due to the suicide of her [serving] twin brother, yet there is no support as she was not a dependant in DVA's view'.¹⁸⁰
148. The Veteran Family Advocate Commissioner, Ms Gwen Cherne, told us in her statement that tailored grief support, psychoeducation and postvention does not exist for the bereaved veteran family community.¹⁸¹ She raised concerns about the limited scope of eligibility and issues with the current definition of family for the provision of postvention support by DVA:

Currently, family members of veterans are generally only eligible for many forms of support if they are wholly or partially financially dependent on the veteran. This has the effect of excluding family members – such as parents of veterans – who are not financially dependent, and do not require financial support, but may need to access other forms of assistance, such as bereavement support. This might include access to support networks, and inclusion in programs like psychoeducation.¹⁸²

149. Veteran families have argued for a long time that the current definition is too limited and means there is no avenue for providing meaningful support to many who need it. They continued to push for DVA to expand its definition of ‘family’ at the DVA Female Veteran and Families Forum from 2016 to 2022.¹⁸³ At the 2022 forum, participants stated:

We would like to talk to you about what a veteran’s family is. And a veteran’s family is anyone that a veteran says is their family. So, it’s not just the spouse and the children. It’s the parents, friends, cousins, and former partners of the veterans. If a veteran still considers them family, then they are family.¹⁸⁴

150. Legacy’s Melbourne office also spoke to the unsuitability of DVA’s definition of family in supporting families:

the Government’s definition of a family is neither representative nor standardised. Even with the different definitions of a family across agencies, Melbourne Legacy sees many individuals, including parents, partners, ex-partners, and re-partnered ex-partners who play essential roles in supporting their veteran, fall outside any of the parameters, which means they also fall outside of formal legislative framework.¹⁸⁵

151. In its 2022 report, *The Recognition for Members of the Australian Defence Force Who Were Killed as a Result of Service*, the Defence Honours and Awards Appeals Tribunal pressed for the need for family to be ‘defined flexibly so as to recognise the changed and changing nature of family structures in modern society and cultural sensitivities’.¹⁸⁶ The report also argued that the process of seeking recognition and establishing eligibility should ‘do no further harm to veterans or families and should, so far as possible, promote wellness and rehabilitation’.¹⁸⁷

152. The limited definition of family is not the only issue with DVA’s eligibility for postvention support. Family members must also prove that the suicide was service-related in order to access any supports other than Open Arms counselling.¹⁸⁸ The legislative complexity and burden of proof needed to access DVA support following the suicide of an ex-serving member mean that many families become discouraged and overwhelmed, and simply give up.

The burden of proving that suicide was connected to service

153. Under the MRCA and VEA, the Statement of Principles Concerning Suicide and Attempted Suicide outlines the minimum factors that must exist (and be relevant to the member’s time in service) before it can be determined that a member’s service led to their death by suicide.¹⁸⁹

154. The VEA and MRCA provide for two different standards of proof that are applied when assessing compensation claims under the Statement of Principles, depending on the type of service rendered:
- The ‘reasonable hypothesis’ standard is applied to serving and ex-serving members who have operational experience.
 - The harsher ‘balance of probabilities’ standard is applied to serving and ex-serving members with Defence and peacetime service.¹⁹⁰
155. Establishing the link between an accepted condition and death under the MRCA and VEA is primarily done by:
- scrutinising a copy of the death certificate, which needs to be obtained in all cases, or
 - direct communication with or a written report from a doctor who treated the client during their last illness.¹⁹¹
156. Under the DRCA, deaths via self-inflicted and intentional injury are not deemed to be compensable.¹⁹² However, if the death by one’s own hand was deemed to not be ‘intentional’, by virtue of that person having ‘lost the power of volition’ due to a compensable mental illness, then there *is* a liability to pay compensation for the death.¹⁹³ In other words, death compensation is only payable if:
- medical evidence from a person with psychiatric expertise demonstrates that the person suffered from a mental disease to which ADF employment had contributed ‘to a material degree’¹⁹⁴
 - medical evidence from a specialist psychiatrist’s examination of that person shortly before the suicide, or other sound medical evidence, demonstrated that the person had lost the ability to choose not to die by suicide. Also, that this state of mind was due to a compensable condition.¹⁹⁵
157. If there is insufficient evidence at hand to fulfil the conditions in the Statement of Principles, families will not be able to prove that the death was service-related.¹⁹⁶
158. Families often believe that their loved one’s death by suicide was related to their service (that there was a ‘service nexus’), but may have limited avenues to produce evidence, especially if they are unable to access legal assistance.¹⁹⁷ Furthermore, the fact that a family is unable to prove that their loved one’s death had a connection to their service does not necessarily mean that there was no connection. Nor does it lessen the impact of the suicide or the heightened risk of suicidality in those bereaved.¹⁹⁸
159. Findings have been made regarding the link between distress caused by the claims process and the deterioration of veteran mental health.¹⁹⁹ As stated in a submission made on behalf of the Bird family to the inquest into the death of their son Jesse, an ex-serving member who died by suicide:

Jesse Bird went to war. He came home with the invisible scars of trauma. Despite his pain and struggles, he did all he could to pave his own way and look after himself. Eventually, at the lowest and most difficult time of his life, he reached out to DVA for help. For Jesse, asking for help was a huge step; one that he normally felt was a weakness. Asking for help took great courage, but instead of help, DVA responded with an approach of delay, deny, and defence. DVA's actions were a direct cause of Jesse's death.²⁰⁰

160. Submissions have spoken to the emotional toll, and the sense of betrayal and burden, of attempting to access support from DVA after a veteran suicide and being denied bereavement claims.²⁰¹

161. Lived-experience witnesses told us about a callous lack of empathy from DVA when their loved one had died by suicide, especially when family members were not deemed eligible for compensation.²⁰² For example, Mr Peter Jenkins said 'DVA needs to stop being an insurance company ... they need their staff to be more empathetic and understanding of the situation of the people contacting them'.²⁰³ He stated:

We found DVA to be the most unhelpful organisation we have ever dealt with. Upon contacting DVA to see if we could obtain a copy of Shaun's medical history with the military, Sue was immediately advised that she was not entitled to any money because she was not Shaun's partner or child ... Sue tried to explain that she was not after compensation but just wanted medical records so she could find out more about what had happened to our son.²⁰⁴

162. There doesn't appear to be anything like a 'no wrong door' approach, or a system of warm referrals whereby family members can access services and information they need when seeking assistance from DVA. This points to the inadequacy of a hyper-bureaucratic system in providing support in the aftermath of suicide, and the significant risk of this re-traumatising families who are simply seeking help. Ms Jasmin Carmel told us of her experience when seeking records from DVA:

I rang them up and there was no empathy. It's like, 'You are not going to get compensation.' I'm like, 'That's not why I'm ringing'. I gave up. I knew I could go through Freedom of Information and forms, but I didn't have the strength.²⁰⁵

163. Although referring to the US context, a report by the RAND Corporation argued that veterans' affairs departments need to be sensitive 'to [the] administrative burdens associated with accessing benefits, particularly [for] those who have suffered a sudden loss'.²⁰⁶ It stated that 'those who lose someone to suicide should not be punished [by administrative processes] for the way in which their loved one died'.²⁰⁷

Even eligible families face significant delays in receiving support

164. Even when family members are eligible for support from DVA, we heard that they often face significant delays in accessing it. One reason for this is that a compensation determination cannot be made until a DVA delegate has received a copy of the death certificate.²⁰⁸ A death certificate is needed:

- to validate the fact of the former or current member's death
- to provide the legal underpinning for any determination on compensation
- because it records the official medical opinion on the cause of the death, which must be demonstrated to have derived from a service-related cause.²⁰⁹

165. Families of ex-serving members who died by suicide told us of significant delays in receiving coronial death certificates and in subsequent liability claims. This led to postvention support being provided long after the families most needed it.²¹⁰ For example, one anonymous author of a submission said that due to these delays she needed to work two jobs to support her family after the suicide of her husband. She wrote:

It took the coroner 13 months to issue an official cause of death ... The delay in the Coroner's Court to issue an official Death Certificate was due to the backlog they were experiencing, which I understood at the time to be quite normal for them. However, that delay caused a knock-on effect for DVA to process our claim, resulting in my need to work 2 jobs at the most vulnerable time in my children's lives.²¹¹

166. The Goodwin family told us they waited a long time to receive the support they were eligible for after the suicide of their son, Ryan. They submitted a DVA claim for funeral payments on 5 February 2020. After receiving no outcome, the family made a submission to the Minister for Veterans' Affairs. The minister's response asked DVA 'to make every effort to resolve Mr Goodwin's outstanding claims and the family's request for official commemoration as quickly as possible'. These claims were finally accepted on 16 June 2021, 18 months after Ryan's death.²¹²

20.6.3 DVA needs a wider remit for providing postvention support

167. If DVA is to provide adequate postvention support to veteran families and the military community bereaved by suicide, it will need to expand beyond its current definition of family and its current scope. This should happen even if compensation systems and processes remain as they are for service-related deaths, as we believe postvention should be decoupled from these processes.

168. Suicide results in social and economic costs to people, families, communities and the nation as a whole.²¹³ There were 1,600 deaths by suicide of current and former serving ADF personnel between 1997 and 2020. This means a minimum of 1,600 service families were affected by suicide loss in this period alone.²¹⁴

169. This does not even cover how many friends, colleagues, first responders and clinicians have been impacted. As Dr Karen Bird, the mother of Private Jesse Bird stated:

The two [veteran] police officers that ... were called to [retrieve my son] Jesse's body ...

... they stressed the importance to John and to my brothers [of] insisting on an open Victorian coronial inquest into Jesse's death because they, as Victorian police officers, were sick of turning up at the suicide of their ex-friends and associates.²¹⁵

170. Military and Emergency Services Health Australia (MESHA) highlighted the need to genuinely grapple with the problem of suicide due to its ripple-like effects in the community:

Given the rippling impact that the suicide of a current and former military or emergency services personnel members has within their community, this issue has the potential to not only represent a tangible threat to our nation by increasing further risk of suicide but is a real and transparent health risk to their families and communities.²¹⁶

171. This Royal Commission itself was established based on the advocacy of serving and ex-serving members and their families who have been negatively affected by Defence and DVA culture, and by the suicide and suicidality of themselves and their loved ones. This reflects the profound, significant and long-lasting effect suicide has had on the entire military community.²¹⁷

20.6.4 More needs to be done for bereaved families and the veteran community

172. According to MESHA, in recent years there have been numerous efforts by DVA and Defence to develop a postvention response for the families of serving and ex-serving members who have died by suicide. However, these efforts have been largely uncoordinated, and 'they have not been truly codesigned, by authentically listening, incorporating, responding to the voices of those who are most impacted'.²¹⁸
173. MESHA's research found that the Australian Government has pledged \$2.3 billion for mental health and suicide prevention in recent years. However, there remains almost a complete absence of resources, instructions and guidance to inform postvention support for families and peers of military personnel who die by suicide. As MESHA stated in its submission:

It's not a case that they didn't ask for help – it's that when their hand reached out for it, there was nothing to give.²¹⁹

A collaborative approach to postvention for the military community

174. The ADF and DVA, in collaboration with veteran organisations and non-government organisations, are in a good position to facilitate a network of resources, information and support for all members of the military community affected by suicide. This community has a strong identity and shared experience of service life. As Lived Experience Australia shared in its submission: 'Underpinning support with help-seeking was recognition that the veteran ... job is different from other jobs, with particularly strong role identity attached for the person and community.'²²⁰
175. Given their contact with the military community, the ADF, DVA and ex-serving organisations (ESOs) are well placed to tailor interventions that are most likely to be effective for this cohort.²²¹ A network of postvention resources might look like:
- improved notification of families, and collaboration between stakeholders so families are actively referred to supports tailored to their needs and circumstances
 - protocols and built-in referral pathways, so that when a veteran or military family presents to police or coronial systems, the service knows what supports may be appropriate for them (for example DVA, ESOs or postvention organisations)
 - a variety of resources and supports that are accessible to those who need them, including practical, peer-based supports; grief and bereavement counselling or therapy; and supports for children and young people
 - relationships between civilian and military organisations to facilitate military cultural education so that community postvention services are culturally competent and can be tailored to the military community
 - connections between people bereaved by suicide and those with lived experience to offer a model of coping and recovery
 - greater dissemination of information about supports across the network, and relationships between service providers so that organisations (such as ESOs, which have frequent contact with the veteran population) can refer individuals under their care to postvention resources where the need becomes apparent.
176. These changes would result in better, more timely postvention and would help families and serving and ex-serving members receive the support they need. Effective postvention would have a ripple effect in terms of reducing adverse consequences associated with suicide bereavement. This would reduce the risk of future suicidality within the Australian community at large.

Postvention support should be co-designed

177. In creating a network of postvention resources, Defence and DVA should engage with those who have lived experience of suicide bereavement.²²²
178. Suicide Prevention Australia spoke about the importance of including those with lived experience ‘in each aspect of the support and suicide prevention system – from service and system design to program delivery and evaluation’:

Voices of lived experience are vital in understanding what works and what doesn’t work, and need to be incorporated and privileged in reforms to improve suicide prevention for Defence personnel and veterans. Just as the broader mental health and suicide prevention systems are moving towards ever-greater leadership positions, co-design and participation of people with lived experience, Defence must systemically respect and incorporate lived experience leadership to improve its mental health and suicide prevention response.²²³

179. Engaging with families who have experienced military suicide can itself be therapeutic for people who have lost their loved one to suicide. It can offer families a sense of closure and an opportunity to pass on knowledge to prevent others from going through similar circumstances. It also offers the bereaved a chance to finally be heard.²²⁴ Ms Glenda Weston shared her son’s story, which gave her hope for change:

I just would like to say that I’m grateful to have been given the opportunity today to publicly verbalise the trauma of my son and [what] our family endured after Bradley faithfully served his country. Today I have only told a part of Bradley’s story. My many years of pleas for help have come to this. This is the last thing I can do for my son. I will never have him back or hear his cheeky laugh. I will never see his beautiful face again. But I can try to continue to fight for some kind of change that may help his former colleagues and his future ADF comrades.²²⁵

The importance of peer support

180. Many bereaved families told us that they would like to be able to share their experiences with other families in the same situation.²²⁶ Support groups can be beneficial in many ways.²²⁷
181. From submission authors and several lived-experience witnesses we heard about the social isolation people often feel after losing someone to suicide. They spoke of the benefit of engaging with people who had also lost loved ones to suicide.²²⁸
182. Providing opportunities for survivors to become peer supporters for others has been found to have many benefits. For example, peer supporters are found to have better post-traumatic growth and a renewed sense of positive meaning in life.²²⁹ A study of post-traumatic growth of participants in the US Tragedy Assistance Program found that being a peer support or peer mentor is a valuable experience for suicide-bereaved people. As the study stated:

The elements of what makes for successful peer support or peer mentoring echo some of the basic principles of the facilitation of post-traumatic growth with an expert companion. This includes the recognition of the trauma response as a precursor to growth, modelling emotion regulation, constructive self-disclosure, and creation of a coherent trauma narrative with domains of post-traumatic growth. If done well, the peer support–recipient relationship is one of shared ‘shattering’ of the assumptive worldview and an ‘existential re-evaluation’ producing wisdom, life satisfaction, and purpose in life.²³⁰

183. Many family members who had lost a loved one to military suicide told us that they had begun volunteering, participating in programs, or informally supporting other families who had lost someone to suicide. Many of them, understanding the pain of loss, wish to be there for others.²³¹ Ms Jasmin Carmel talked about helping a fellow military mother who had lost her son to suicide:

I was advised of a funeral the next day and that a young man was being brought home for his funeral. I made contact with his mother and told her I was there to support her. Her son had died by suicide and he was an ex-serving member of the ADF. I attended the funeral to show the families love and solidarity and because I know that you often don’t know who to turn to.²³²

184. Ms Nola Hedger spoke about being involved in several suicide prevention and postvention organisations:

I have been touched by suicide and death throughout my life ... For many years now, I have volunteered as a support worker with the Fraser Coast Suicide Prevention Network. Our network reach[s] out to those who have lost loved ones by suicide. We do a lot of work with headspace, Wesley Mission and Lifeline. We raise money and attend conferences in regional areas to network and build our support services.²³³

185. Mr John Armfield told us that despite experiencing trauma over the way Defence handled his brother’s suicide, he would like to have the opportunity to ‘utilise the knowledge [he has] gained’:

I have a passion to assist those in similar situations to mine ... My goal is to work with the ADF, not against [it]. I have seen enough suicides and mental [ill] health within the organisation.²³⁴

186. There are currently no formal peer support groups available for military families bereaved by suicide. Ms Janet Kuys, whose son died by suicide, wrote:

There were no support groups for us to turn to. We met with many counsellors to help but none knew how to handle a situation like ours. They were lacking expertise particularly with understanding mental health for defence members and defence issues and suicide.²³⁵

187. According to evidence received from DVA, the Open Arms community and peer program does not have a dedicated suicide bereavement peer support service.²³⁶

Bereavement support for young people

188. If a comprehensive network of bereavement resources is to be established, dedicated support is needed for children and adolescents. Children who have lost a parent to suicide are three times more likely to die by suicide than their peers.²³⁷ Children need to be recognised as needing grief and bereavement services in their own right. Such services should be funded accordingly.
189. Many children who have lost a parent to suicide have been exposed to cumulative traumatic events in the lead-up to the death. For example, they may have witnessed suicide attempts, the poor mental health of that parent, substance abuse and family violence.²³⁸
190. Professor Louise Newman, an expert in childhood intergenerational trauma, stated that when children are exposed to long-term stressors it deeply affects them. They need to be evaluated so support can be offered commensurate with what they have experienced.²³⁹
191. Several submissions from families, including children, described the long-term impact of their loved one's poor mental health prior to their death.²⁴⁰ As a teenager, Ms Kamaia Alexander witnessed her step-father's three suicide attempts. She saved his life several times prior to his death.²⁴¹ She spoke about the impact of this overall and on her childhood:

I had to grow up way too quick and that's evident now in my behaviours and I think that is going to stay the way it is, that I never got to be young and innocent and stupid and all those things. I had to grow up really quick and it will take a toll.²⁴²

[I] have been impacted by the effects of my father's mental health my entire life ... Dad was eventually diagnosed with post-traumatic stress disorder and depression. He also became a chronic and severe alcoholic in an attempt to self-medicate.²⁴³

192. Lived-experience witnesses also described the impact on children of losing a parent to suicide.²⁴⁴ Ms Madonna Paul spoke about her children's post-traumatic symptoms and suicidality after the death by suicide of her partner.²⁴⁵ Another anonymous submission told us that after the suicide of her husband, her daughter began self-harming and developed a neurological condition:

People deal with grief differently. Some people get angry or depressed, others, like me, escape it by working or travelling non-stop. And others still, like my daughter, start self-harming ... she started internalising her grief and disengaging from everyone.²⁴⁶

193. Given the prevalence of suicidality and risk for suicide-bereaved children, it is critical that appropriate support be available for them. However, there is a general consensus among researchers that mental health services currently available to children of

serving and ex-serving members are insufficient.²⁴⁷ There are no services specifically designed for the children of military personnel who die by suicide.²⁴⁸ As stated by Melbourne Legacy:

The Federal Government has a duty to those who served to meaningfully show that they are acknowledging the issues faced by their families, that they are accepting and taking liability of the intergenerational trauma experienced by their children, and that they are responding to their unmet needs.²⁴⁹

194. The Australian Kookaburra Kids Foundation's Defence Kids Program is the only mental health support program in Australia specifically for children of Defence families.²⁵⁰ The organisation hosts camps that provide age-appropriate mental health education, as well as daily 'chat groups', to build mental health literacy, coping skills and resilience. These camps currently reach out to young people in Defence families living with a parent who has PTSD or other mental illness. The camps aim to build a support network of peers in similar circumstances.²⁵¹

Recommendation 77: Develop a suite of postvention resources in collaboration with stakeholders

Defence and the Department of Veterans' Affairs should fund and facilitate the development of a postvention network of suicide-bereavement resources in collaboration with ex-service organisations, states and territories, lived experience peers, and civilian support organisations to augment current postvention offerings, which can be inclusively accessed by and are tailored for the military community and all those affected by veteran suicide.

Endnotes

- 1 K Andriessen and others, *Evidence Check: Suicide Postvention Services*, NSW Ministry of Health, June 2020, p 6 (Exhibit M-01.071, DVS.3333.0001.5222).
- 2 National Action Alliance for Suicide Prevention, *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines*, April 2015, p 18; Australian Institute for Suicide Research and Prevention & Postvention Australia, *Postvention Australia Guidelines*, 2017, p 9 (Exhibit 23-03.048, Hearing Block 3, STU.0003.0001.0697).
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21 Moral injury

Summary

The term ‘moral injury’ was coined by clinical psychiatrist Dr Jonathan Shay in the mid-1990s during his 20 years as the sole psychiatrist of a United States Department of Veterans Affairs outpatient clinic in Boston. It is a relatively new concept for an age-old experience deeply connected to the horrors of war. According to Dr Shay, ‘moral injury is present when there has been (a) a betrayal of ‘what’s right’; (b) either by a person in legitimate authority ... or by one’s self ...; (c) in a high stakes situation.’¹

Other researchers in the field have described moral injury as what can happen when a person perpetrates, fails to prevent or bears witness to acts that transgress deeply held moral beliefs and expectations.²

Moral distress and moral trauma are related concepts that sit on a continuum with moral injury. While moral distress is a normal experience that passes over time, when a person experiences moral injury or moral trauma, it is likely to be intense and long lasting, with emotional, psychological, behaviour and spiritual effects.

While a person may experience both moral injury and post-traumatic stress disorder (PTSD), they are different. The traumatic incident that leads to PTSD tends to involve a threat to life or safety and catalyse strong fear-based emotions. The incident that causes moral distress and can lead to moral injury, by contrast, need not be personally threatening. It tends to trigger emotions of shame and guilt.

Some people consider moral injury as a ‘wounding of the soul’. As one former serving member who had been [redacted] said:

I don’t see many people with suicidal ideation that want to kill themselves because of their post-traumatic stress. It’s been described by people: ‘I feel like I have a wounded soul, that I’ve done something really wrong or I witnessed something that was really wrong and I didn’t do anything about it.’ And this is my life experience: these are the things that lead to veterans’ suicide.³

Moral injury, therefore, while not as well understood and well documented as PTSD, is critical to our inquiry. It is deeply connected to the tragedy of suicide and suicidality of serving and ex-serving members, as this quote demonstrates.

In this chapter, we examine the connection between moral injury, suicidality and suicide, we outline the risks of moral injury during and after service, and we investigate protective factors against moral injury, as well as how it can be prevented and treated early.

While we do make a specific recommendation about moral injury in this chapter, many of the recommendations of our final report aim to shift structural conditions and military culture in the Australian Defence Force (ADF) so that moral injury is less likely to occur. The conditions in which moral injury may arise include: lack of leadership accountability; inadequate debriefing opportunities, safe places to vent, mental health care and postvention; lack of procedural fairness in military justice processes; a perceived gap between what a policy says and what ‘actually occurs’; a culture where being tough and ‘sucking it up’ is equated with psychological resilience; and a tacit culture of tolerating interpersonal violence and derogatory behaviour.

As such, our recommendations in the areas of leadership, governance and accountability, sexual misconduct, unacceptable behaviour and complaints management, recruitment and training, deployments, health care, military justice and the Inspector-General of the ADF, and support for ex-serving members, are all connected, if indirectly, to shifting the conditions within Defence and Department of Veterans’ Affairs (DVA) so that the incidence of moral injury can be minimised.

In Dr Shay’s words:

My version of moral injury is something we can do something about. It is, to a degree, within our control.⁴

We agree.

21.1 Introduction

1. This chapter discusses moral injury and its relevance for serving and ex-serving ADF members in the context of mental health, suicidality and suicide.
2. Although the concepts of moral distress and moral injury are relatively early in their development from a scholarly perspective, understanding of them is evolving quickly.⁵ Researchers and clinicians are beginning to better understand what moral injury is and how it occurs; and how it can be prevented, diagnosed and treated. Furthermore, as moral injury begins to be more recognised and understood, more data will become available, leading to better evidence. Strategies for its prevention, early identification and treatment are likely to improve.⁶
3. Military service doubtless presents moral and ethical dilemmas and members’ values may be challenged or transgressed. There are often complex and competing obligations to be navigated in service life. In a warlike deployment context, for instance, the needs of an individual member, the needs of the unit, the demands of the mission and the needs of the civilian population where they are serving may be in tension, sometimes unreconcilably so.

4. Members may experience moral injury in combat and non-combat environments. Its effects may be felt during or after service, regardless of when the triggering incident occurred.
5. As Bryan and colleagues state:

[P]sychological strategies such as emotional suppression and experiential avoidance are also frequently used [by defence force members] as adaptive responses to the realities of combat. Suppressing fear, anger, grief, and self-doubt to remain calm and focused ... is highly adaptive [for] the service member.⁷
6. It is therefore sometimes the case that the emotions and psychological symptoms associated with moral injury only surface some time later, either when it is safe to process them, or when they can no longer be suppressed.
7. During warlike operations, ADF members may 'witness, be required to carry out, or fail to stop, violence or other inhumane or cruel acts towards others'.⁸ Experiences such as these are likely to be morally distressing and may result in moral injury.
8. In non-combat environments, we heard evidence of poor leadership, military interpersonal violence, military sexual violence and toxic elements of military culture resulting in moral injury.⁹
9. ADF members and ex-serving members are not alone in experiencing moral injury; their family members may also be at risk.¹⁰ Research indicates that people in 'first-responder' occupations, including the police, healthcare workers and journalists, may also be at risk of moral injury.¹¹
10. Research suggests there is a relationship between moral injury and mental health conditions such as post-traumatic stress disorder (PTSD), depression and anxiety. It also suggests that moral injury is linked with psychosocial issues including social issues, relationship breakdown, substance misuse, aggression and feelings of embitterment.¹²
11. Research based on overseas military populations shows an association between moral injury and suicidality, comprising suicidal ideation, suicide plans and suicide attempts.¹³ While the studies informing this body of research did not include ADF members and ex-serving members and while, as at June 2024, no specific research has been done on the association between moral injury and suicidality in the Australian context, we contend that the findings of these overseas studies are nevertheless relevant.
12. For this reason, Defence and DVA should adopt the language of moral injury in forming an understanding of the psychological distress experienced by serving and ex-serving members. They should conduct research to better understand, diagnose and support treatment for moral injury. They should stay up to date with international research in order to implement strategies to minimise the onset of moral injury in serving and ex-serving members and to treat it effectively when it occurs.

13. We acknowledge Dr Nikki Jamieson’s significant contribution to research on moral injury in Australia and globally. Dr Jamieson is a suicidologist, social worker, researcher and the mother of Private Daniel Garforth, who died by suicide in 2014 while serving in the Australian Army. Dr Jamieson gave evidence concerning both her lived experience of suicide and her expertise on moral injury.¹⁴ We thank Dr Jamieson for her enduring commitment to progressing the research on this topic.

21.2 What is moral injury?

14. A range of definitions exist for moral injury. In this section, we provide an overview of some of the ways moral injury is defined, noting that there is no consensus definition.
15. We also report on prevalence data from overseas, noting that data on prevalence in Australian military populations is lacking, and we discuss the symptoms associated with moral injury.

21.2.1 Defining moral injury

16. The term ‘moral injury’ was coined by Dr Jonathan Shay in 1994 while working as the sole psychiatrist in a veteran outpatient clinic in Boston. He worked with profoundly traumatised veterans of the Vietnam War.¹⁵ Dr Shay has done extraordinary work for many decades, advocating for changes in policy, practice and culture aimed at preventing psychological and moral injury.¹⁶
17. While there is some variation in the literature as to an exact definition, broadly speaking, moral injury refers to the ‘response that can occur following events that violate a person’s moral or ethical code’.¹⁷ These events are referred to as ‘potentially morally injurious events’ (PMIEs). PMIEs are generally ‘categorised into one of three types: perceived transgressions by self, perceived transgressions by others and perceived betrayal’.¹⁸
18. Different types of PMIEs may provoke distinct responses¹⁹ and perhaps even more significantly, as trauma psychologist Mary Harvey wrote: people ‘are not equally vulnerable to nor similarly affected by potentially traumatic events’.²⁰ As she put it: ‘[I]ndividual differences in posttraumatic response and recovery are the result of complex interactions among person, event, and environmental factors.’²¹
19. Environmental factors that are unique to military contexts are, therefore, significant, both in terms of how they may make serving and ex-serving members susceptible to moral injury, but also in terms of the kinds of solutions that might be most effective.
20. Moral injury can profoundly affect a person’s sense of self and others, as well as their world view and belief system.²² In Dr Shay’s words:

[Moral injury] impair[s] and sometimes destroy[s] the capacity for trust. When social trust is destroyed, it is replaced by the settled expectancy of harm, exploitation and humiliation from others.²³

21. In their seminal 2009 paper, Brett Litz and his colleagues sought to define moral injury in defence and veteran populations. They described moral injury as the:
- lasting psychological, biological, spiritual, and social impact of perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.²⁴
22. Litz and colleagues argued that:
- moral injury involves an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness. How this dissonance or conflict is reconciled is one of the key determinants of injury. If individuals are unable to assimilate or accommodate (integrate) the event within existing self- and relational-schemas, they will experience guilt, shame, and anxiety about potential dire personal consequences (e.g., ostracization). Poor integration leads to lingering psychological distress, due to frequent intrusions, and avoidance behaviors tend to thwart successful accommodation [integration of the event].²⁵
23. Transgressive and betrayal-based moral injury is closely related to the term ‘moral distress’; however, moral injury and moral distress are different. While moral distress is ‘normal and serves an adaptive function for society’, moral injury ‘goes beyond the experience of distressing moral emotions, is pervasive and enduring ... across psychosocial and spiritual domains’.²⁶
24. Moral distress and moral injury exist on a continuum, with moral injury at the severe end, being associated with greater functional impairment and more extreme symptoms.²⁷
25. The relative severity of moral injury should not undermine the importance of recognising and assessing for moral distress. Moral distress can reduce performance and organisational commitment and indeed lead to moral injury if it endures or the cause of it is not removed.²⁸ Early identification of moral distress may therefore prevent moral injury.
26. In 2016, Jeremy Jinkerson further developed Litz’s 2009 definition of moral injury. Jinkerson identified guilt, shame, spiritual/existential conflict and loss of trust as ‘core symptoms’ of moral injury. Jinkerson argued that these symptoms can develop when a person’s moral beliefs are violated, when a person is betrayed, or when a person witnesses trusted individuals committing atrocities.²⁹ According to Jinkerson, depression, anxiety, anger, re-experiencing self-harm and social problems are ‘secondary symptoms’ of moral injury.³⁰
27. In their 2020 literature review and concept analysis on the subject, authors Dr Nikki Jamieson, Myfanwy Maple, Dorothy Ratnarajah and Kim Usher redefined moral injury as ‘moral trauma’. They defined moral trauma as ‘the existential, psychological, emotional and or spiritual trauma arising from a conflict, violation or betrayal, either by omission or commission, of or within one’s moral beliefs or code(s)’.³¹

28. While understandings of moral distress, moral injury and moral trauma, and their interrelationships, continue to develop, they all speak to well-established ideas of one's moral framework. This can be thought of as 'fundamental assumptions about how things should work and how one should behave in the world' and 'the personal and shared familial, cultural, societal, and legal rules for social behaviour, either tacit or explicit'.³²
29. As Litz and others wrote in 2022, the idea 'that people can be lastingly psychologically and socially affected by their own or others' transgressive behaviors is as old as humanity'.³³ As Dr Jamieson said:

Our moral frameworks are what make us us. Dr William Nash calls [them] our love system. Everything we do is centred around our moral framework. It's everything we believe in, it's everything we consider to be a value to us.³⁴

30. On the subject of an individual's moral code, Litz and others gave the following account:

The majority of individuals have a strong moral code that they use to effectively navigate through their lives ... For example, the implicit belief that 'the world is benevolent' stems from the expectation that others will behave in a moral and just manner. Another tacit assumption is that 'people get what they deserve'; thus, if someone does not act within the accepted moral code, a punishment should ensue.³⁵

31. Dr Jamieson gave evidence concerning the moral frameworks of ADF members:

For Defence members, for instance, they will fight and die for their country. Their moral framework is deeply embedded in that strong sense of loyalty to their country, their love for their country, their love for the Defence Force.³⁶

32. Dr Jamieson and others wrote in 2021:

An act or event through omission or commission that creates a conflict of or within one's moral framework is considered morally injurious ... An example of an act or event in this context is causing harm or death of civilians, giving orders that result in injury or death of a fellow service member, failing to report sexual assault, bullying or violence against oneself, a fellow service member or civilians, following orders that were illegal or immoral.³⁷

33. As Associate Professors Ben Wadham and James Connor stated in a submission additional to their evidence:

[T]he strong emotional bonds of loyal mateship create a further moral injury risk when a member feels that they have failed or let down their mates. This injury is caused by feelings of blame and consequent regret at their actions.³⁸

34. As Defence and DVA grapple with the reality of moral distress and moral injury and look to integrate contemporary understandings of these concepts into their frameworks for preventing harm and promoting wellbeing, it is crucial to address the complexities of defining, assessing and treating moral injury. As Molendijk and others stated in a 2018 article:

Questions about the nature of morality, how morality can be injured, and the consequences of such injury are complicated and should be taken into account when working out conceptual models with regard to moral injury. When this complexity is not addressed, implicit and unsubstantiated assumptions about the nature and role of morality are easily incorporated, leading to a rather insubstantial basis for the development of both the concept of moral injury as such and clinical practices based thereupon.³⁹ Jamieson and others, in their research on the association between moral injury and suicide behaviour in the military population, are critical of definitions of moral injury that ‘placate leadership and/or chain of command regarding their contribution to moral injury among veterans’.⁴⁰

35. In 2017, Hodgson and Carey had made a similar warning, stating:

Whether deliberate or unintentional, diminishing the responsibility of organizational leadership, can subsequently minimize and undervalue the sense of betrayal perceived by current and former serving personnel, and effectively exonerate corporate culpability and the liability of organizations with respect to moral injury.⁴¹

36. While knowledge of the causes and contextual factors of moral injury continue to develop, the literature does consistently indicate that moral injury is multidimensional.⁴² It is not merely a psychiatric or psychological concept, but has clear social, philosophical and spiritual dimensions as well. For example, a person’s religious, spiritual or philosophical beliefs may be deeply affected by an experience of moral injury, as could the social and political ideas that shape their ideas of morality.

21.2.2 Prevalence of moral injury and its associated symptoms

37. There is a lack of data on the prevalence of moral injury among Australian military populations. However, research on US military personnel has shown that exposure to PMIEs is associated with various psychiatric symptoms.⁴³
38. In a 2021 review of the history, definition, measurement, prevalence and impact of moral injury, Koenig and Al Zaben found that:
- more than 90% of 373 US veterans surveyed reported high levels (9 or 10 on a 1-to-10 severity scale) of at least one symptom associated with moral injury
 - 59% reported five symptoms or more at this level of severity.

39. Further, in a study of 103 active-duty military personnel with PTSD symptoms, the authors found that more than 80% had at least one symptom of moral injury of high severity and 52% had four or more such symptoms.⁴⁴
40. There is also research indicating that moral injury is common among active-duty armed forces personnel of other countries too. For example, in 2021, Hodgson and others noted the high rate of exposure to PMIEs in a qualitative study of 10 Australian veterans, while the work of Levi-Belz and others in 2020 and Williamson and others in 2021 discusses the impacts of moral injury on the UK and Israeli armed forces respectively.⁴⁵
41. In terms of the lasting effects of moral injury, in 2022, Dr Andrea Phelps, Deputy Director of Phoenix Australia, and others noted the symptoms of moral injury as including:
- enduring and pervasive feelings of guilt, shame, anger and disgust; thoughts of being bad, damaged or unworthy; loss of trust in others; and spiritual outcomes such as loss of faith in previous religious beliefs and loss of belief in a just world.⁴⁶
42. In a 2022 review on moral injury, Phoenix Australia, the national centre for post-traumatic mental health, categorised the adverse outcomes reported by veterans and serving members with lived experience of moral injury into the following four domains:⁴⁷
- **Emotional effects**, which can include feelings of guilt, shame, anger, sadness, anxiety and disgust.⁴⁸ These can be felt in a way that causes considerable turmoil and distress.⁴⁹
 - **Intrapersonal effects** (occurring within the person), which can include lowered self-esteem, high self-criticism, beliefs about being bad, damaged, unworthy or weak, and self-handicapping behaviours such as denying oneself pleasure and self-sabotaging opportunities to succeed.⁵⁰ These could manifest in high-risk or self-destructive behaviours such as substance abuse or neglect of self-care. Intrapersonal outcomes can affect one's outlook on life, sense of hope in the future, and ability to meet one's goals.⁵¹
 - **Interpersonal effects** (occurring between the person and others), which can include the loss of faith in people, avoidance of intimacy and lack of trust in authority figures.⁵² They can manifest in isolation, poor relationship outcomes and joining 'fringe' social groups such as gangs.⁵³
 - **Spiritual/religious effects**, which can include existential changes associated with shattered beliefs about morality and humanity.⁵⁴ These can affect an individual's ability to derive meaning from life, and cause them to develop less tolerant moral expectations of themselves or others.⁵⁵

21.3 Identifying and treating moral injury

43. Research on treatment to support those affected by moral injury is in its infancy. There are, however, emerging concepts that could inform the care of those impacted.
44. In this section, we stress the importance of early detection and summarise the evidence we have heard on emerging approaches to treatment and support.

21.3.1 Early identification and assessment of moral injury

45. It is accepted that when outright prevention is not possible, identifying mental health issues early creates the best opportunity to successfully treat them.⁵⁶ We surmise that this is also the case for moral injury, particularly if it can be identified as moral distress and successfully resolved before it manifests in its more extreme form.
46. Identifying moral injury is complicated by the fact that there are no universally accepted diagnostic criteria. Moral injury is not included in the Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or in the International Classification of Diseases, 11th Revision (ICD-11). That is not to say that it should be, given the multidimensional nature of moral injury; however, the absence of consensus diagnostic criteria does raise the question of how it is to be identified.
47. Research into developing a recognised assessment tool for identifying, assessing and measuring adverse outcomes of moral injury is in its infancy. Phoenix Australia has been involved in a project to develop the Moral Injury Outcome Scale (MIOS),⁵⁷ collaborating with an international consortium of researchers and clinicians working with active-duty military service members and veterans in the United States, the United Kingdom, Israel, Australia and Canada.
48. Dr Phelps gave evidence about the consortium and what it aims to achieve:

The Moral Injury Outcome Scale Consortium ... is an international effort that we are part of, but led by Professor Litz at Boston University, to develop a ... reliable and valid scale to assess moral injury in all of its components across psychological impacts, social impacts, existential impacts.⁵⁸
49. Phoenix Australia said that the MIOS can be ‘used in clinical practice and epidemiological research as a reliable and valid measure of moral injury outcomes’, using guidance on administration and scoring published in its summary report.⁵⁹
50. Further, Phoenix Australia stated:

The MIOS can be used in research and clinical settings as part of a mental health assessment to identify exposure to a potentially morally injurious experience and assess the presence and severity of any moral injury outcomes. Similarly, it can be used pre- and post-treatment to assess any change in MI [moral injury]

symptoms following treatment. Written user instructions containing an explanation of the administration and scoring will be available to researchers and clinicians administering the MIOS.⁶⁰

21.3.2 Support and treatment for moral injury

51. Research on supports and treatments for those affected by moral injury is also in its infancy, and as of June 2024, it is not known whether they are effective.⁶¹

52. As Dr Jamieson and others stated in a study published in 2021:

Globally, the prevalence of moral injury remains unknown. Therefore, assumptions about presentations of moral injury would need to be carefully considered until a suite of rigorous and robust tools become[s] available to determine the population affected. There has also been limited exploration into treatment approaches for moral injury. Therefore, more research is needed.⁶²

53. We heard evidence from witnesses with various kinds of expertise in different approaches to supporting serving and ex-serving members experiencing moral injury.

Creating narratives of transformation

54. Dr Jamieson told us about a clinical approach that involves working with people affected by moral injury to make sense of the experience and from there, to create narratives of transformation that support the person to find their purpose and identity again:

You start with the veteran's experience and what the feelings are associated to that experience. As a clinician, you would work through that process ... [and] work towards repurposing some of those experiences into the mission, the greater good, again. It's about developing meaning-making and purpose.

Q. And acknowledge, repurpose, reclaim?

A. Yes.

Q. Transformation of identity?

A. Yes.

Q. And reframe?

A. Yes, absolutely. It's helping them to accept what has happened, their role in what has happened, and to validate and reconcile some of those negative emotions that might attach to those experiences.⁶³

55. The key stages in the approach shared by Dr Jamieson are:
- to acknowledge the moral impacts of military service
 - to 'repurpose' the experience into a positive activity with purpose
 - to reclaim the experience, including what happened and why, and making space for acceptance and forgiveness
 - the transformation of identity, by which the person can say 'I am not that person anymore' and recognises that they can grow, move past it, and use their experience to help others
 - to reframe the experience as something more positive.⁶⁴
56. Dr Jamieson's evidence stems from research she undertook with colleagues into the lived experiences of moral injury for Australian veterans. The study identified three themes: meaning-making and moral injury, narratives of transformation, and leading the charge.
57. The findings of the study led to three conclusions:
- First, all of the participants had experienced a moral injury that resulted from their or another's actions or failures to act, and when the other was in a position of power, such as command or a clinician, it was more significant.⁶⁵
 - Second, when serving and ex-serving members experience moral injury, questions of identity are very important, as is how they make meaning of the experience. The authors state that 'when one's core identity is threatened, especially if founded in trauma such as killing or military sexual trauma ... a person's meaning-making agency and self-identity can also be damaged'. Damage of this kind can 'heighten the risk of negative feelings and suicide behaviour in veterans'.⁶⁶ The authors said that 'how veterans make meaning of their experience is an important consideration in suicide prevention approaches'.⁶⁷
 - Third, the study found that 'transformation is possible', and is the kind of healing required. For transformation to occur, 'acceptance, reconciliation, and validation [of the meaning the veteran ascribed to the experience] are needed'.⁶⁸
58. The study found that while transformative healing *is* possible when veterans are supported to make their own meaning and to have it understood and validated, very little research had been done on exactly how to support veterans through that process.⁶⁹

Building trust and being non-judgemental in the face of perceived guilt

59. Dr Katelyn Kerr, a clinical psychologist who has worked with ADF members, gave evidence about the importance of addressing the guilt that is often symptomatic of moral injury:

We were interested in what guilt does in terms of suicide attempts in our veteran population that we see with PTSD in our programs. We are interested in that because there is exploding research and interest in the concept of moral trauma and moral injury. Moral injury is currently recognised as something that is distinct from PTSD, and there are four constructs that make up moral injury and moral trauma. One of those is guilt, and the other three are shame, self-condemnation and betrayal ...

We know that guilt, irrespective of mental illness diagnosis, has been associated with veteran suicides in the US and we know that in other studies it actually plays a really big role in people not getting better in trauma recovery programs. The worse someone's guilt is, even if they have very high PTSD and very high guilt, they have the worst outcomes on trauma recovery programs, but for people that have very high PTSD but low guilt, we find the outcomes are excellent. So it goes to show the role that guilt actually plays in mediating some of these relationships, but also probably just being a very important concept on its own.⁷⁰

60. Dr Kerr said:

in someone who has got guilt plus significant PTSD, we can treat the PTSD ... and that can resolve some, if not all of the guilt they feel, if that is related and tied in with the trauma. In other circumstances ... guilt can be quite different to what happened in their trauma, and ... we have to look at a different way of treating that, which is often going to be with cognitive therapy, so looking at what is the meaning that they have made [of] that event, and then how do we construct other meaning that is helpful, that is believable, that is true as well, it's not about unicorns and rainbows, this has to be something that is true, that they can then buy into and have a new concept of what that event means.⁷¹

61. Dr Kerr also said that supporting people with moral injury in a non-judgemental way was particularly important given how strong their feelings of guilt can be. Trust in the therapeutic relationship is also crucial:

[T]he therapeutic relationship [is so important] ... because a person is not going to tell you about the things that are causing them guilt unless they have developed that bond with you and that trust with you. They have to know that you can carry that, and that you are going to be non-judgemental about whatever they have done or didn't do in the situation that gave rise to that guilt. So that's a really important element.⁷²

62. This echoes Dr Shay's experience:

First, last and always, the question of trust is on the table, regardless of what forms of moral injury are in play. 'Why should I trust *you*?' is a question asked, both verbally and behaviourally, a thousand times in the course of clinical work with every morally injured veteran ... This makes sense when you recall what fills the vacuum when trust is destroyed: expectancy of harm, exploitation and humiliation.⁷³

63. Dr Kerr went on to say:

In the literature [on] moral injury, they also talk about making reparation and finding a way in which to ... apologise [when the person themselves has acted in a way that transgressed their moral code], which is pretty difficult ... whe[n] you are employed overseas, or to make amends. It may not be making amends to the people that were actually harmed or that you couldn't protect, but it might be making amends in other ways and then that would tap into the concept of post-traumatic growth which is, '[b]ecause bad things have happened in my life, I can do better and I can be better', and be driven by those things to actually achieve more.⁷⁴

Contemporary models and looking towards post-traumatic growth

64. In a 2022 article, Phelps and others point to the fact that a lot of contemporary research into moral injury focuses on 'approaches to psychological resilience including the potential for posttraumatic growth'.⁷⁵ They also refer to Rozek and Bryan's psychological model of moral injury that 'suggests an interaction between:

- predisposing factors (eg, social support, cognitive flexibility and emotion regulation)
- moral stressors (eg, taking a life)
- responses, including cognitions (eg, I'm a bad person), emotions (eg, guilt and shame), physical reactions (eg, pain and insomnia) and behaviours (eg, social isolation).⁷⁶

65. This model highlights the importance of *preparing* 'for the ethical and psychological challenges presented by PMIEs by enhancing cognitive flexibility and emotion regulation, and building effective leaders and cohesive teams in preincident resilience training'.⁷⁷ The model further suggests that 'early intervention post-PMIE should address any problematic responses, helping the individual come to terms with the PMIE through individual, or shared, disclosure and discussion of opportunities for learning or reparation'.⁷⁸

66. Phelps and others argue that moral injury interventions should not focus solely on the individual. They say that contemporary approaches to psychological resilience have moved beyond individual resilience training programs and have 'an increasing recognition of the importance of group factors such as leadership and team cohesion'.⁷⁹

67. The work being done in the field of moral injury creates many opportunities for Defence and DVA to design interventions aimed at:
- reducing susceptibility to moral injury by increasing the protective factors of social support, cognitive flexibility and emotional regulation
 - increasing the clinical support provided to serving and ex-serving members who have experienced moral injury, recognising the centrality of trust, and therefore continuity of care, in the therapeutic relationship and the importance of the collective as well as the individual by focusing on group cohesion and effective leadership
 - recognising that the thoughts, emotions, physical reactions and behaviours associated with moral injury must, as a priority, be addressed in suicide prevention efforts.

The spiritual dimension of moral injury and holistic approaches to healing

68. We also heard evidence that moral injury can have spiritual or religious dimensions. For this reason, when responding to the moral injury experienced by serving and ex-serving members whose moral framework is based on religious faith or spiritual belief, a solely medical/psychological model of healing may not be appropriate.
69. Some treatments, including those employed by the United States Department of Veterans Affairs, draw on the religious and spiritual dimensions of moral injury, and focus on rebuilding the individual's spiritual relationships.⁸⁰
70. Phoenix Australia states the following with respect to treatment approaches:

Although the quality of the evidence base is ranked as unknown, the biopsychosocial and spiritual impacts of moral injury suggest that overall a combined intervention approach may be optimal, whether that is via a biopsychosocial treatment augmented with a spiritual approach, or a truly integrated treatment approach.

Such approaches need to consider the role of practitioners and ensure that clinical and spiritual practitioners work closely together. Future research should prioritise the development and testing of a multidisciplinary psychosocial spiritual model of intervention for moral injury, including consideration of how to effectively address the spiritual component of moral injury amongst veterans who are either non-religious or who have strong religious convictions for a particular religion.⁸¹

71. We believe more research into supporting and treating serving and ex-serving members experiencing moral injury is needed. In addition, there is a need to build greater awareness of moral injury, especially among those working with the ADF community, so they can provide support to those who need it, particularly as the evidence base about treatment develops. We make a recommendation on this in section 21.6.3 of this chapter.

21.4 Associations between moral injury, mental ill health, suicide and suicidality

72. According to a 2022 Phoenix Australia review of the association between moral injury and symptoms of mental ill health, ‘there is a strong, complex relationship between moral injury, depression, PTSD, and suicidality in veteran and military populations’.⁸² We summarise this evidence in the following section.

21.4.1 Associations between moral injury, PTSD, depression and anxiety

73. Speaking to the clinical validity of the construct of moral injury, researchers Litz and others state that ‘service members and veterans can suffer long-term scars that are not well captured by the current conceptualizations of PTSD or other adjustment difficulties’.⁸³
74. In the same vein, the authors of the review by Phoenix Australia state that ‘emerging evidence indicates that clinically, moral injury is a mental health issue independent of PTSD and depression, and contributes uniquely to risk of suicidality’.⁸⁴
75. Theoretical models of PTSD conceive of the traumatic incident as inciting fear, often mortal fear, whereas moral injury is constructed as a violation of one’s moral code, associated with shame, guilt, self-condemnation and feelings of betrayal. Moral injury can destroy people’s trust and shake deeply held beliefs about themselves and others.⁸⁵
76. Dr Phelps gave evidence on this distinction and the relationship between moral injury and PTSD, noting:
- it really is a recognition that initially it was in relation to people with PTSD, that some of the experiences that people have are not just based on the fear paradigm, the idea of life threat, but there are also events that can occur that really transgress what people feel is right ... [S]omething they see, something they may have even done, or that they have experienced, such as feeling betrayed by people in positions of authority, it goes against their moral code. So this whole idea of moral injury is that it is about feeling shame, guilt, those betrayal experiences, but then, that having a lasting impact in the way that people think about themselves and about other people.⁸⁶
77. Interestingly, Dr Phelps went on to clarify that moral injury:
- [is] not a mental health disorder, it’s more a pattern of responses that can occur to these particularly severe moral stressors. But the research to date would suggest that it can certainly lead to mental health disorder. And it’s also been found in some large US studies of combat soldiers who have experienced these sorts of events, that it is associated with suicidality, above and beyond deep depression and PTSD.⁸⁷

78. Recent neurological evidence supports this distinction. Although in its early stages, research based on functional MRI scans shows differences between the activation of the brain in individuals presenting solely with PTSD and individuals who present only with moral injury.⁸⁸
79. Williamson and colleagues' 2020 article refers to the work of Bryan and others, who found that military personnel who had developed PTSD from life-threatening trauma experienced memory loss, nightmares, flashbacks and an exaggerated startle response.⁸⁹ In contrast, the symptoms experienced by those with moral injury are more likely to include guilt, anger, shame, depression and social isolation.⁹⁰
80. While symptoms of moral injury and PTSD overlap to some degree, they are distinct experiences. Overlapping symptoms may include depression,⁹¹ anxiety and negative self-worldviews,⁹² non-moral emotions, disinterest in pleasurable activities and detachment from others.⁹³ Most scholars, however, agree that the two are distinct.⁹⁴ Thus, 'one can have PTSD without moral injury, moral injury without PTSD, or both together'.⁹⁵

21.4.2 Associations between moral injury, suicide and suicidality

81. Many contemporary studies show a statistical association between moral injury and suicidality.⁹⁶ Feelings of guilt, in particular, and also shame, which are commonly associated with moral injury, have also been associated with increased severity of suicidal ideation.⁹⁷
82. Authors of a US study involving 1,321 combat veterans concluded that reports of PMIEs are associated with increased risk for suicidal behaviour, 'above and beyond [risks associated with] severity of combat exposure, PTSD, and depression'.⁹⁸
83. Similarly, as Dr Kerr highlighted in her evidence:

[G]uilt, irrespective of mental illness diagnosis, has been associated with veteran suicides in the US and we know [from] other studies it actually plays a really big role in people not getting better in trauma recovery programs.⁹⁹
84. A study involving a nationally representative sample of 14,057 US veterans examined the association between moral injury, mental health and suicide attempts during military service and after separation by gender in post-9/11 veterans. The study investigated veterans' experiences of PMIEs as perpetrators (in which they acted, or failed to act, in a way that transgressed their moral code), as witnesses or as the one betrayed.¹⁰⁰
85. The authors concluded that exposure to a PMIE:

accounted for additional risk of suicide attempt during and after military service after controlling for demographic and military characteristics, current mental health status, and pre-military history of suicidal ideation and attempt.¹⁰¹

86. In 2023, Jamieson and others published a systematic review that analysed 12 studies investigating the association between moral injury and suicidality (suicidal ideation, plans and/or suicide attempts) among serving and ex-serving personnel.¹⁰²
87. The authors conclude:
- [A]nalysis of these twelve studies consistently affirms a connection between moral injury and suicide behaviour; most obviously, that exposure to morally injurious events substantially amplif[ies] the risk of suicide, with higher levels of potential exposure being linked to increased moral injury and heightened levels of suicidal behaviour.¹⁰³
88. Studies have also shown how moral injury can adversely affect a person's relationships and work. Many affected individuals report relationship breakdowns and unemployment due to distress related to PMIEs.¹⁰⁴
89. Given the emerging evidence, Defence and DVA must put more work into preventing moral injury as far as possible, and when it does occur, to identify it early, and assess and treat it effectively. Undetected and untreated, moral injury may lead to suicidality,¹⁰⁵ and we know that those who experience suicidality are at a higher risk of suicide.¹⁰⁶

21.5 Risks of exposure to potentially morally injurious events

90. During our inquiry, we have received a substantial amount of evidence that military service, military culture and military organisational and operational stressors all convey risk of exposure to PMIEs. Factors that affect members post-transition may also exacerbate previously experienced moral distress or moral injury. Taken together, they increase the risk of serving and ex-serving ADF members experiencing moral injury.

21.5.1 Risks of moral injury during service

91. Defence itself has identified that some military circumstances and environments can lead to moral injury in some individuals. The ADF Chaplaincy Moral Injury Biological Psychological, Social and Spiritual Impact flip book identifies the following situations that may cause a member to develop moral injury:
- following orders that are illegal or immoral
 - knowingly or accidentally causing deaths of civilians in combat
 - giving orders that result in the injury or death of a fellow service member or civilian
 - failing to provide medical assistance to an injured civilian or service member
 - neglecting to report a sexual assault committed against a civilian or service member.¹⁰⁷

92. Additionally, in the context of organisational betrayal, perceived transgressions by others and perceived betrayal, Defence also identified the following circumstances that may give rise to moral injury:

- an individual reports abuse and feels unsupported by their leaders
- doing the right thing results in rejection, isolation and punishment
- an individual follows orders only to feel betrayed by a leader who denies all knowledge
- when wrongdoing is covered up and the victim is denied a voice.¹⁰⁸

93. Some researchers with lived experience have discussed the ways in which the unique context of military service increases the susceptibility of members to moral injury. According to Dr Jamieson and others:

The core duty of the ADF is to protect Australian land, air, and sea, and the citizens who live within Australia. To perform this duty requires a collective mentality and adherence to predetermined codes of group behaviour. From recruitment, individual moral values are reimaged with military codes and values. Individualism is replaced with collectivism through stringent military training regimes, a command structure, and ritualization ...

A veteran's role is to listen [to], understand, and execute orders. Actions required of veterans can demand split-second decision-making. These decisions can affront existing moral frameworks resulting in moral injury.¹⁰⁹

94. According to Associate Professors Wadham and Connor, speaking on behalf of all new recruits:

We join bright eyed, we seek to contribute to a greater force, we are proud of our service. When the institution betrays you, treats you poorly, unfairly, this generates significant distress.¹¹⁰

95. Similarly, in their 2020 article, Dr Jamieson and others talked about the cultural conformity of military life, in which members are socialised to adopt the attitudes, values and goals of the organisation. This unique context increases their risk of moral injury:

Fundamentally, the military's core business is combat and being a collective undertaking, the importance of 'honour' cannot be underestimated. Honour in military service means collectively adhering to military cultural, legal and moral codes, whilst doing what is always 'right' and making decisions that are in the best interest of the military as opposed to oneself. Thus, when ethically, morally or spiritually oriented tensions present, such as orders resulting in injury or death of colleagues or leadership betrayal, a moral injury can occur.¹¹¹

96. Dr Kerr and others found that workforce shortages contributed to conditions that may make moral injury more likely, namely increased demands, longer and more frequent deployments and a lack of time for processing challenging experiences. They wrote:
- Veterans who had served in conflicts post-East Timor were more likely to experience traumatic guilt [a key component of moral injury], possibly because of increased demands on contemporary defence force personnel with longer and more frequent deployments resulting in more repeated exposure to tragedy and horror or a potential time bias due to a lack of time to process military experiences.¹¹²
97. Phoenix Australia similarly found that multiple or longer deployments mean that members may have greater cumulative exposure to PMIEs while being subject to fatigue and emotional drain, which themselves decrease resilience and the emotional regulation needed to process moral distress.¹¹³
98. Aspects of modern warfare may also increase risks of moral injury. Counter-insurgency operations, and those involving non-uniformed enemies and potentially hostile civilians, pose extreme ethical challenges.¹¹⁴ Combat scenarios such as these radically increase the likelihood of civilian harm and the kinds of PMIEs that can result in moral injury.¹¹⁵
99. In a 2016 article, Jinkerson identified changes in training, combat protocols and combat scenarios during and since the Vietnam War that drastically altered the experience of combat for US military personnel and radically increased the risk of moral injury.¹¹⁶ Those changes include:
- 77%–87% of US personnel firing their weapons in Vietnam and post-Vietnam engagements, compared with fewer than 25% in World War II and 50% in Korea
 - modern combatants being trained to ‘shoot on-order when instructed’, leading to ‘reflexive battlefield killings’
 - a significantly high proportion of military personnel (40%–65%) reporting having killed enemy combatants in Operation Iraqi Freedom.
 - the increase in non-uniformed enemies and potentially hostile civilians, which has led to the killing of larger numbers of people who were, or may have been, civilians: up to one in four reported killing non-combatants and more than one in 10 reported injuring or killing women, children or the elderly.¹¹⁷
100. While these findings relate to US armed forces personnel, they represent general trends in modern warfare and some of the contextual factors align with those experienced by ADF members during this same period.
101. We commissioned qualitative research from Associate Professor Wadham based on with serving and ex-serving ADF members and family members of those who had died by suicide.¹¹⁸ ADF members and ex-serving members reflected on the ‘moral challenges’ inherent to active service, including peace-keeping duties. For example, an officer who served in the Navy between 1997 and 2005 spoke about the poor preparation he and his colleagues received for a peace-keeping mission to Timor:

[W]hat they didn't really prepare [us] for was the fact that the place was at war ... we were never given any weapons and we were constantly put in situations where people were shooting and threatening to kill us, all for the sake of delivering some humanitarian aid to the local church, which – by the time we got there – had blown up anyway.¹¹⁹

102. Dr Jamieson and others discussed the fact that while active deployment to a conflict zone increases exposure to PMIEs, not all serving members who experience moral injury have been deployed:

Deployment to active service heightens risk of developing [moral injury]. Service experiences and other military-related traumas such as exposure to killing and/or military sexual trauma can create environments whereby moral codes are betrayed or violated, thus creating an environment for [moral injury] to develop. However, [moral injury] has been reported among those who have not ever been deployed, suggesting that other activities of training or being in the military can also transgress moral codes.¹²⁰

103. As Dr Jamieson alludes to in this quote, a PMIE can also be a catastrophic leadership failure. Examples of such failures, all of which we have heard evidence of occurring, include a more highly ranked member perpetrating violence or sexual assault; discouraging or stymying the reporting of such conduct; and perpetrating 'administrative violence' – that is, using their discretionary power to harass or intimidate a lower-ranked member. In these instances, the resultant moral distress or moral injury can be worsened by members' strong sense of duty, habituation to obeying orders and socialisation to trust the chain of command and the institution.

104. Dr Jamieson said when she gave evidence:

[B]etrayal from leadership [is] a significant contributing factor to moral injury, particularly in military environments. Given the context of the training and indoctrination and the heavily enforced values of loyalty, commitment and honour, it is not too difficult to see how those frameworks can be impacted when leaders who are supposed to have somebody's back or the system that is supposed to have somebody's back, lets them down.

Moral injury is considered a life-span trauma across the whole identity. As I said, the distrust and betrayal are significant features which impact social connection, which then impacts the feelings of belonging and ... heightens suicide risk.¹²¹

105. Dr Jamieson talked about broken promises and false expectations being morally injurious:

People have this expectation going into Defence that Defence will have their back, leadership will take care of them, everybody will look after each other, there's a camaraderie and a mateship. I certainly know in Daniel's case that didn't happen to be the case ... [I]t's the expectations before, during and after ADF that were not fulfilled [that] were creating moral injuries for people. So having all

these glossy brochures and saying how wonderful it is to join Defence, but their lived experience was not meeting those expectations, was morally injurious for those people.¹²²

106. We heard evidence of members holding strong beliefs about service and duty that were not shared by superiors. Jeremy Thomas, a former navy clearance diver, told us about raising safety concerns with his chain of command and not having his concerns taken seriously. For him, the dissonance between his own sense of commitment and that demonstrated by the leaders of his chain of command was deeply morally distressing:

I felt at the time that the organisation had sent me and many others into terrible situations and some had paid a great sacrifice, and yet, they were not learning. I took this badly and I felt deeply offended. The Navy requires its people to be agile, adaptive, and execute with precision. But it stops at the individual level, and it was not reciprocated from the officer ranks, or the organisation. I believe at this time I was suffering moral injury.¹²³

107. We heard from psychologist, Dr Jacqueline Drew, Associate Professor at the Griffith Criminology Institute in Griffith University. Speaking about the policing context, she described the feeling of embitterment that often arises when people feel betrayed by the agency they have trusted and served:

So, embitterment is feeling like something has wronged you within the agency. And it's not a fleeting feeling of cynicism or embitterment, it's something you simply cannot let go. It has violated your basic beliefs. And it has some relevancy to organisational betrayal and moral injury.¹²⁴

108. This is highly relevant to the Defence context.

109. The fact Defence agrees that military environments can lead to moral injury in some individuals¹²⁵ is an important and welcome first step. We are also pleased to see some work being undertaken, particularly in relation to training and education.¹²⁶ However, training and education alone is not enough. We urge further action, especially in relation to prevention, early intervention and treatment, which we discuss further in section 21.6.3.

21.5.2 Risks of moral injury post-service

110. The risk of moral injury occurring or coming to light for ex-serving members is also real:
- Moral injury may have occurred during service, but is not fully experienced until after separation from the ADF.
 - The reason for separation – especially involuntary separation – and the manner of separation may be experienced as institutional betrayal and lead to moral injury.
 - Ex-serving members who expect a simple and transparent claims process; ready compensation for service-related injuries; and adequate health care and treatment according to their eligibility, and whose expectations are not met, may experience moral injury.

111. Speaking about the US context, in a 2017 article, McCormack and others describe 'multiple layers of war-related betrayal' and its effects on Vietnam veterans in particular:

Complicating the recovery process following combat experience is an organisational potential to invalidate or poorly support returnees from high-risk environments precipitating feelings of unworthiness and ... self-harming behaviours. Decades after exposure, McCormack and Joseph (2014) found that aging Vietnam veterans experienced multiple layers of war-related betrayal ... Perceived betrayal in hierarchical organisation where staff are exposed to threatening environments, not dissimilar to that experienced by children who suffer abuse at the hands of primary caretakers, appears to play a central and complex role in war-related distress and the potential for moral injury.¹²⁷

112. While not specific to the Australian context, the lessons are general ones, particularly of the greatly magnified significance of institutional betrayal for people who have risked their lives in the service of that institution.
113. Having morally injured ex-serving members places additional responsibility on mainstream health and social services. This can be even more challenging when these services are far removed from the events that caused the moral injury, and may not have the resources to assess or treat those who present with it.

Moral injury experienced by family members of those who have served

114. Finally, we note that moral injury is not only experienced by those who have served as members of the ADF. It can also be experienced by family members of serving and ex-serving members. Lived Experience Australia, an organisation that advocates for and with those with lived experience of mental ill health, their carers and family members, notes in its submission to this Royal Commission:

From our recent research with families, we further found that moral injury was pervasive across the family member participants' accounts of their experiences, and a clear consequence of experiencing organisational barriers to help-seeking.¹²⁸

115. We also received a submission from Rodney Cameron-Tucker, an ex-serving member himself, who told us about his daughter's experience in the ADF. The lack of care shown to his daughter following an injury shook his moral beliefs and values:

My dilemma is that not only did my daughter suffer but I did as well. My moral injury was witnessing and experiencing acts that conflicted with my deeply held moral beliefs, values, and expectations. It upsets me today that many other young people also had to struggle and did not have an ADF experienced father to support them.¹²⁹

116. From everything that we have heard, the reality of moral injury across the Defence community is something that Defence and DVA must address and do everything in their power to mitigate.

21.6 Protective factors and ways of preventing moral injury

117. It is critical that Defence and DVA understand the factors that protect against moral injury, and strategies that can be used to prevent moral distress and exposure to a PMIE from developing into moral injury.

21.6.1 Factors that protect against moral injury

118. Factors that may protect against moral injury following exposure to a PMIE include:

- emotional regulation
- forgiveness of self and others
- perceived social support
- leaders taking responsibility for events
- group cohesion
- empathy from people who have experienced similar events
- the capacity to make meaning of the experience.

119. A 2022 study involving 191 Israeli combat veterans examined how veterans' levels of self-forgiveness and perceived social support interacted with their levels of exposure to PMIEs to influence their experiences of moral injury and suicidal ideation. The study found that veterans with a history of suicidal ideation and behaviours reported higher levels of exposure to PMIEs and lower levels of self-forgiveness and perceived social support than veterans with no history of suicidality.¹³⁰

120. Further, the study found that both self-forgiveness and perceived social support reduced suicidality of veterans. Importantly, the results indicated that PMIEs were related to current suicidality only when low or moderate levels of perceived social support were reported by the veterans.¹³¹

121. The finding that perceived social support may protect against moral injury accords with the research on social support acting as a protective factor against suicide and suicidality in veterans. As the authors of the study state:

Our results confirm previous findings regarding the role of higher perceived social support, which related to lower suicide risk among veterans. However, the unique contribution of this study is in suggesting that perceived social support may act as a buffer in the PMIEs–SIB [suicide ideation and behaviours] link. These findings

may propose that beyond the negative association with SIB, higher perceived social support could help in moderating the harmful ramifications of PMIEs among veterans and play a significant role as a resilience factor for SIB following MI [moral injury] experiences.¹³²

122. A study that examined risk and protective factors associated with moral injury experienced by UK veterans reported that veterans found it helpful when they received empathetic support after the event. This was particularly so when the support came from fellow personnel or veterans who had experienced similar incidents, and leaders who had taken responsibility for events.¹³³
123. Screening for risk and protective factors associated with moral injury in routine suicide risk assessments would also help in identifying those at risk of adverse outcomes of moral injury, including suicidality.

21.6.2 How can moral injury be prevented?

124. In our view, Defence leaders play an essential role in preventing moral injury. Dr Shay, the originator of the concept of moral injury, spells out the need for military leadership to be 'expert, ethical and properly supported'.¹³⁴
125. Phelps and others discuss the importance of the role of military leaders in preventing moral injury from developing after exposure to a PMIE. They state:

[L]eaders can often ameliorate distress by helping members to make meaning of their experiences through discussion after a PMIE (eg, integrated into regular after-action reviews) focused on reinforcing the mission, sense of purpose in the activity, acknowledging the moral dilemmas and reinforcing the principles that guide decision making in this context. However, this should not be done in a way that glosses over the moral complexity of experiences, or fails to acknowledge and address negative emotions such as sorrow, guilt and shame; these efforts are more likely to engender, than prevent, MI [moral injury].¹³⁵

126. Defence leaders who have built cohesive teams may also draw on the wider team to help ADF members resolve moral dissonance through, for example, informal social gatherings with peers.¹³⁶ Further: 'in circumstances where a PMIE involves a potential breach of law, leaders should ensure a clear understanding' of limits to confidentiality, and 'have a clear plan for managing anonymity and arrange appropriate support'.¹³⁷
127. The authors recommend further research on the relationship between reflective practice by military leaders and outcomes of moral injury, 'comparing those [defence personnel] with leaders who employ regular reflective practice with those with leaders who do not'.¹³⁸
128. Along with Defence leaders, chaplains can play a role in identifying and reducing the severity of moral injury for serving members. ADF members may seek out chaplains following a PMIE, especially on deployment where chaplains may be a first point

of contact.¹³⁹ Canadian military studies found that personnel exposed to PMIEs were more likely to seek help from a religious or spiritual advisor than a mental health professional.¹⁴⁰

129. Nonetheless, mental health professionals play an important role in assisting those at risk of or experiencing moral injury, including through early intervention and reducing the negative impact of moral injury. Phelps and others provide the following guidance:

Psychological approaches to MI [moral injury] include standard evidence-based treatments for PTSD, adapted PTSD interventions and new interventions targeting MI specifically. The core experiences of guilt, shame and anger associated with MI have led to a focus on forgiveness in targeted psychological interventions: self-forgiveness for things that the individual has done or failed to do themselves and forgiveness of the other for events involving betrayal or moral transgression on the part of someone else. The importance of opportunities for corrective experience that challenge negative and global attributions and opportunities for reparation has also been emphasised, as has acceptance of experience and commitment to value-based behaviour.¹⁴¹

130. Defence is well placed to further the knowledge on moral injury, prevention, early intervention and treatment, given that many ADF members experience PMIEs during their service. However, this requires a commitment to implementing and evaluating a range of interventions.

131. As Phelps and others state:

In the absence of established evidence-based approaches, we recommend interventions informed by the nature of MI [moral injury] and contemporary approaches to psychological resilience. These should be embedded into existing military structures and processes designed to enhance operational readiness, including ethics, resilience, leadership and other routine training. Effective implementation of new approaches to mitigate the risk of MI requires leadership commitment, engagement of all stakeholders, ongoing resourcing and rigorous evaluation of outcomes to promote an organisational culture ready to prevent, identify and manage MI, as well as advance the science.¹⁴²

132. On creating the change necessary to address moral injury among ADF members and ex-serving members in Australia, Phelps and others make a number of points:

- (a) Effective change requires support of leadership across all levels.
- (b) Senior leaders must understand the concept and risks associated with moral injury and commit to invest the necessary time and resources to address that risk.
- (c) Formal and informal leaders across all levels of the organisation who can promote prevention and early intervention initiatives and lead by example [are needed].

- (d) To encourage commitment and collaboration among all stakeholders, the planning, design, implementation and evaluation of approaches to address moral injury should involve personnel and their families, as well as military leaders, chaplains and mental health practitioners.
- (e) Need to identify and address factors that drive systemic barriers to equity and inclusion (eg, racial, ethnic, gender or sexual identity). This may involve, for example, discussion of the intersectionality between moral injury and diversity in ethics training, ensuring diversity among the identified formal and informal moral injury leaders, and having more than one avenue for individuals seeking support.
- (f) Capacity and capability to deliver new approaches to addressing moral injury need to be developed and reinforced in an ongoing way. In an environment of competing demands for organisational resources and the inherent challenge of discussing moral ambiguities in a military culture that may not generally favour questioning, efforts to address moral injury are unlikely to be sustained without a continued focus.
- (g) The approach to addressing moral injury needs to have enough flexibility to be adapted in different circumstances, without loss of fidelity. For example, the core elements of discussing PMIEs in ethics training or after-action reviews may be agreed upon, but the timing and emphasis given to different elements may change depending on the unique circumstances of each deployment.¹⁴³

21.6.3 The need for further action

- 133. Much of the research on moral injury, especially on assessing and treating it, is still in its early days. In the Australian context, noting the commendable work of Dr Jamieson and others, there is much that research is yet to illuminate. This includes how prevalent moral injury is, and effective strategies to prevent it from occurring among serving and ex-serving ADF members.
- 134. The early work suggests that there is support and treatment that shows promise. As the research develops, Defence and DVA should incorporate these learnings into the support they offer and continue to develop prevention, assessment and treatment approaches for serving and ex-serving members and their families.

Recommendation 78: Prevent, minimise and treat moral injury

Defence and the Department of Veterans' Affairs should work collaboratively to develop an agreed approach to minimising the negative impacts of moral injury, including the risk of suicide and suicidality for serving and ex-serving members. The approach should evolve in line with emerging research and best practice, and at a minimum include:

- (a) implementing education, training and support programs with the explicit objectives of preventing, minimising and treating moral injury
- (b) considering using the Moral Injury Outcome Scale or other tools, as the evidence base evolves, to support the early identification and treatment of moral injury
- (c) conducting or commissioning further research to better understand moral injury in the Australian military population.

Endnotes

- 1 J Shay, 'Moral Injury', *Psychoanalytic Psychology*, vol 31, 2, 2014, p 182 (Exhibit 04-02.006, Hearing Block 1, EXP.0001.0022.0017).
- 2 BT Litz and others, 'Moral Injury and Moral Repair in War Veterans: a Preliminary Model and Intervention Strategy', *Clinical Psychology Review*, vol 29, 8, 2009, p 695.
- 3 Patrick Lindsay, Submission, ANON-Z1E7-QEX7-C, p [15] of supplementary material.
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- 5 Phoenix Australia, *The Current Status of Moral Injury: a Narrative Review and Rapid Evidence Assessment*, August 2022, p 11 (Exhibit S-01.002, DVS.0012.0001.5949).
- 6 V Williamson and others, 'Moral Injury: the Effect on Mental Health and Implications for Treatment', *Lancet Psychiatry*, vol 8, 6, 2021, p 454 (Exhibit 08-06.031, Hearing Block 1, EXP.0001.0015.0464).
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- 14 Transcript, Nicola Jamieson, Hearing Block 1, 29 November 2021, pp 1-52 [39]–1-53 [42], 1-54 [9–43]; Transcript, Nicola Jamieson, 2 December 2021, pp 4-345 [42]–4-367 [40].
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22 Mefloquine and tafenoquine

Summary

Mefloquine and tafenoquine are medications taken to prevent and treat malaria. Their use by defence personnel has been a focus of several previous inquiries, both in Australia and internationally.

Both drugs are known to cause side effects, including psychiatric symptoms.

None of the inquiries or studies that we reviewed have been able to demonstrate a definitive association between the use of these drugs and long-term health impacts. However, we note that they have brought to light significant individual and anecdotal evidence around adverse health impacts. Importantly, several also noted the need for more and better additional data and further research.

We recognise that the symptoms experienced by some serving and ex-serving members following their use of mefloquine and tafenoquine are real, and we note their severity. We also recognise the impact that symptoms have had on the lives of members and their families.

We received public submissions, including from serving and ex-serving members, who shared their experience of serious health issues that followed their use of antimalarial medication in the Australian Defence Force (ADF).

This chapter explores the use of mefloquine and tafenoquine by the ADF, including previous clinical trials that were undertaken in the late 1990s and early 2000s in which members were participants. Submissions we received also raise issues about the manner in which these trials were conducted. We note that these matters have been the subject of a previous Inspector-General of ADF review and no adverse findings were made.

The chapter also describes Defence and Department of Veterans' Affairs response to members' concerns about mefloquine and tafenoquine use.

22.1 Introduction

1. Exposure to serious disease is one of the many risks Australian Defence Force (ADF) personnel face on deployment. One such disease is malaria. It is caused by a *Plasmodium* parasite, which is transmitted to humans by the bite of an infected *Anopheles* mosquito.¹ Two of the five species of *Plasmodium* parasites affecting humans (*Plasmodium falciparum* and *Plasmodium vivax*) account for the majority of malaria cases.² If left untreated, both can lead to severe illness and death.
2. Malaria has caused casualties in all of the ADF's major conflicts since World War I. It severely impacted the Australian Army's combat operations in Palestine in 1918, in New Guinea in 1943 and in Vietnam in 1968.³ Defence has allocated significant resources to malaria research, training, control, prevention and treatment.⁴
3. The medications Defence uses to prevent malarial infection include atovaquone-proguanil (Malarone), doxycycline, primaquine (Primacin), mefloquine (Lariam) and tafenoquine (Kodatef).⁵ The *Defence Health Manual* provides that doxycycline is the first-line preventative treatment, but tafenoquine and atovaquone-proguanil may also be used.⁶
4. The *Defence Health Manual* recommends that '[d]ue to the potential for severe adverse events in some people, mefloquine is to be used by those who have previously tolerated the medication or for whom other antimalarials are inappropriate choices'.⁷
5. Apart from Defence's routine prescription of anti-malarial medications to its personnel, through the Army Malaria Research Institute (AMRI – now known as the Australian Defence Force Malaria and Infectious Diseases Institute), it also tested mefloquine and tafenoquine in its personnel in four clinical trials. These are discussed in section 22.5.

22.2 Defence personnel and mefloquine and tafenoquine

6. Mefloquine and tafenoquine are linked to a number of side effects, including psychiatric symptoms.⁸ As a result, these drugs are 'contraindicated', or not advised for use, where an individual has a history of psychiatric illness. This is because of their potential to interact with, or exacerbate, these conditions.⁹
7. There is less certainty about whether these drugs can cause longer-term, permanent, adverse health impacts. We discuss the research in more detail in section 22.6.2.
8. We received public submissions, including from serving and ex-serving members, telling us about their personal experiences taking mefloquine and tafenoquine, including experiences of psychiatric symptoms.

9. Mr Shane Granger, an ex-serving member who was part of the mefloquine trial, told us:

Mefloquine sent me insane. I attempted suicide in 1997, 1998, 1999, 2000, and 2014. When I finally confirmed what the Army had done to me in early 2019 I was angry but also a little relieved. I could finally die with a little peace.¹⁰

10. Mr Stuart Bartlett, who served in East Timor, told us:

I was part of the Antimalarial Drug Trial in 2000, on deployment to East Timor on UNTAET. I was given tafenoquine for 6 months, upon returning no follow-up tests were conducted eg, 6, 12, 5 and 10 years. Multiple mental breakdowns have occurred over the past and 15 suicide attempts.¹¹

11. Submissions this Royal Commission received also detailed concerns about the conduct of AMRI's clinical trials, including whether informed consent was obtained from Defence personnel who were given mefloquine and tafenoquine.¹² This matter has been the subject of previous inquiries, including an Inspector-General of the ADF inquiry in 2015 and Senate committee inquiry in 2018.¹³ We note there have not been adverse findings around the ethical conduct of the ADF regarding the antimalarial trials.
12. Defence continues to prescribe mefloquine and tafenoquine to ADF personnel, even though in low numbers.¹⁴ Both medications are listed on the Australian Register of Therapeutic Goods (ARTG) and are available for prescription generally. However, in our view, there are legitimate questions about their suitability for Defence personnel.
13. The issues discussed in this chapter raise questions about the adequacy and effectiveness of clinical governance within Defence and Department of Veterans' Affairs (DVA). As representatives of Defence and DVA acknowledged, the quality of clinical governance is directly relevant to delivering high quality care and positive clinical outcomes for serving and ex-serving personnel.¹⁵ Expert evidence supports this.¹⁶ Serving and ex-serving members, their families, their carers, the health service organisations that treat them and the community, ought to be confident that Defence and DVA have appropriate clinical governance structures to deliver safe and high quality health care, continuously improve their systems and services, and be accountable for delivering such systems and services.
14. We have explored various aspects of clinical governance and accountability within Defence and DVA in Chapter 16, ADF healthcare services and Chapter 18, Health care for ex-serving members. This chapter illustrates those issues.

22.3 Mefloquine

15. Mefloquine is an anti-malarial drug. It was discovered in a research program at the Experimental Therapeutics Division of the Walter Reed Army Institute of Research in the United States. The program started in 1963 following significant deaths from malaria in soldiers during the Vietnam War.¹⁷ Roche obtained marketing approval for mefloquine in Switzerland in February 1984.¹⁸ After approval in Europe and the United States, mefloquine was registered on the ARTG for the prevention and treatment of malaria.¹⁹
16. Mefloquine is now used for the treatment of acute attacks of malaria caused by *Plasmodium falciparum* infections resistant to conventional anti-malarial drugs. It is also used for malaria prevention for those travelling to countries with *P. falciparum* infection resistant to other drugs.²⁰ Mefloquine was not subject to Phase III clinical trials to further test its quality, safety and efficacy before it was granted regulatory approval in Australia and elsewhere.²¹ The Australian health authority justified this as it concluded the benefits outweighed the risks after considering clinical need, therapeutic options and available data at the time.²²

22.3.1 Side effect profile

17. Not long after mefloquine's approval, consumer and scientific reports started examining its side effects regarding adverse events.²³ In 1991, the first large study reporting an increased risk of neuropsychiatric side effects due to mefloquine was published (the Petersen Study).²⁴
18. In 1991, the World Health Organization, in collaboration with manufacturer Roche, published a 'Review of Central Nervous System Adverse Events Related to the Anti Malarial Drug Mefloquine (1985–1990)'.²⁵ This followed serious neurological and psychiatric adverse events being attributed to mefloquine. Of the 640 adverse event patients reviewed, 245 (38%) had neurological and psychiatric side effects.²⁶ Of those 245, five patients with a major psychiatric disorder and one patient with other psychiatric symptoms were suicidal (and two attempted suicide).²⁷
19. Later reports identified an 'increased risk of severe neuropsychiatric side effects'.²⁸ Others reported that, when comparing mefloquine with chloroquine plus proguanil '[t]he risk ratios clearly showed that mefloquine users had a significantly increased risk of symptoms from the central nervous system'.²⁹ The predominant symptoms included depression, altered spatial perception and strange thoughts (being 'thoughts of an unpleasant nature, which [study participants] ... had never had before').³⁰
20. By 1997, the Walter Reed Army Institute of Research in the United States began looking for a new treatment to prevent malaria; one that was free from neuropsychiatric disturbances experienced by some people using mefloquine. Tafenoquine was identified as a potential option and became the subject of the Defence trials we examine in section 22.5.³¹

21. By the time Defence began the clinical trials, the then current Australian *Product Information* (dated 11 September 1998) for mefloquine identified the following contraindications, precautions and adverse reactions:

CONTRAINDICATIONS – ... Patients with a past history of psychiatric disturbances or convulsions should not be prescribed Lariam [mefloquine] prophylactically.

PRECAUTIONS – ... Caution should be exercised with regard to driving, piloting aircraft and operating machines, since dizziness, disturbed sense of balance and neuropsychiatric reactions have been reported during and up to 3 weeks after use of LARIAM.

ADVERSE REACTIONS – ...Psychiatric disorders: ... somnolence, sleep disorders, ... anxiety, depressive mood, confusion, restlessness, forgetfulness, hallucinations, and psychotic or paranoid reactions.³²

22. Defence has confirmed it was 'aware of mefloquine's neuropsychiatric side effect profile before the clinical trials on Defence personnel were commenced'.³³ Defence notes 'Mefloquine was a registered medicine in Australia and its product information and consumer medicine information describes potential side effects.'³⁴
23. By 2001 Defence recognised in its clinical trial protocol, *Evaluation of Safety and Adverse Effects of Mefloquine in the Prophylaxis of Malaria in Non-Immune Australian Soldiers*, that mefloquine has side effects. These included 'depression, strange thoughts and altered spatial appreciation' in some people.³⁵
24. Since that time, the *Product Information* and the *Consumer Medicine Information* factsheets for mefloquine have been progressively updated. The current Australian *Product Information* specifies mefloquine should not be used for preventative purposes in patients 'with a past history of active depression, a recent history of depression, generalised anxiety disorder, psychosis or schizophrenia or other major psychiatric disorders or convulsions'.³⁶ The *Product Information* 'Special Warnings and Precautions for Use'³⁷ section notes that during preventative use, signs of anxiety, depression, restlessness or confusion may be precursors to a serious event, and the use of mefloquine should be discontinued. It also notes that neuropsychiatric symptoms and/or adverse reactions may occur or persist for months or longer even after discontinuation because of mefloquine's long half-life.³⁸ The mefloquine *Consumer Medicine Information* provides similar information.

22.4 Tafenoquine

25. In 1978, the Walter Reed Army Institute of Research discovered tafenoquine during its search for a safer, more effective, and longer-acting drug than primaquine.³⁹
26. By 1997, tafenoquine had become a subject of interest in the search for a replacement malaria treatment and preventative drug.⁴⁰ The first clinical trials for tafenoquine were conducted in the late 1990s.⁴¹
27. In July and August 2018, tafenoquine was approved in the United States to cure *Plasmodium vivax* malaria and to prevent malaria in certain patients.⁴² Tafenoquine was approved in Australia in September 2018 (as Kozenis for treatment and Kodatef for prevention).⁴³
28. The current Australian *Product Information* for tafenoquine as Kodatef notes that it should not be used for people with historical or current psychosis,⁴⁴ psychotic symptoms, delusions or hallucinations.⁴⁵ It also states that during clinical trials, adverse psychiatric reactions included sleep disturbances,⁴⁶ depression/depressed mood,⁴⁷ and anxiety.⁴⁸ The current Australian *Consumer Medical Information* for tafenoquine as Kodatef warns consumers that before starting to take it they should tell their doctor if they 'have a psychotic disorder such as schizophrenia'. It says that while taking it, they should seek medical attention if they have a psychotic disorder and their symptoms worsen.⁴⁹ Similar contraindications and warnings are contained in the current Australian *Product Information* and *Consumer Medicine Information* for tafenoquine used for treatment (Kozenis).⁵⁰

22.5 Defence clinical trials

29. Between 1998 and 2002, Defence undertook four clinical trials of mefloquine or tafenoquine (with one of the four trials involving the use of both) on Defence personnel. A summary of each trial is included below.

22.5.1 First clinical trial – tafenoquine

30. In 1999, Defence started a Phase III clinical trial⁵¹ to identify the best tafenoquine dosage regimen for *Plasmodium vivax* malaria acquired in the Southwest Pacific region. The first part of the study was conducted in Bougainville, where 592 participants received varying doses of tafenoquine.⁵²
31. In 2000, Defence personnel returning to Australia from Timor-Leste were recruited to the trial and received the same varying doses of tafenoquine.
32. All studies were compared to the then standard post-exposure preventative administration of primaquine and doxycycline for Defence personnel returning from malaria-endemic areas. The assessment of the tafenoquine dose regimens was based on efficacy and tolerability compared to the primaquine–doxycycline treatment.⁵³ In total, tafenoquine was administered to 1,017 Defence personnel.⁵⁴
33. The only relevant side effect recorded in subjects taking tafenoquine was 'headache'.⁵⁵

22.5.2 Second clinical trial – tafenoquine and mefloquine

34. In 2000 and 2001, the AMRI conducted a further Phase III clinical trial on Australian soldiers on a peacekeeping deployment to East Timor.⁵⁶ Its primary objective ‘was to compare the safety and tolerability of tafenoquine with those of mefloquine in malaria prevention for 6 months’, while its ‘key secondary objective ... [was] to assess the efficacy of tafenoquine in preventing *P. falciparum* and *P. vivax* malaria during and following deployment’.⁵⁷
35. Four hundred and ninety-two soldiers received weekly malaria prevention with tafenoquine followed by a placebo, while 162 soldiers received mefloquine followed by primaquine.⁵⁸
36. Sixty-four (13.0%) tafenoquine subjects and 23 (14.2%) mefloquine subjects reported neuropsychiatric adverse events, the most common being vertigo, dizziness and various sleep disorders. All neuropsychiatric events were reported as mild or moderate.⁵⁹ Twelve tafenoquine subjects (2.4%) and three mefloquine subjects (1.9%) withdrew from the study because of adverse events. Of those, three tafenoquine subjects withdrew for possible treatment-related adverse events including moderate depression and moderate ‘hyperesthesia’ (namely, extreme sensitivity to touch, pain, pressure and thermal sensations).⁶⁰ Other recorded neuropsychiatric adverse events included mild anxiety, agitation, euphoria, tremor, morbid dreams and nightmares and amnesia.⁶¹

22.5.3 Third clinical trial – tafenoquine

37. From July 2000 to May 2001, tafenoquine was used to treat 31 subjects with *P. vivax* malaria who had failed chloroquine and primaquine treatment.⁶² Chloroquine was followed by a three-day loading dose (meaning an initial higher dose) and then weekly dose, for eight weeks, of tafenoquine. Twenty-seven patients completed the full tafenoquine treatment.⁶³ Treatment was stopped early for four patients who were part way through the trial before the sponsor, GlaxoSmithKline, then suspended all tafenoquine clinical trials because of an unexpected adverse event affecting the eyes.⁶⁴ The study report said that no serious adverse events were reported and there were no withdrawals because of adverse events.⁶⁵

22.5.4 Fourth clinical trial – mefloquine

38. The fourth clinical trial was carried out on two cohorts of Defence personnel on peacekeeping duties on the border between East Timor and Indonesia over six-month periods in 2001 and 2002.⁶⁶ A total of 1,157 Defence personnel were administered a loading dose followed by regular weekly doses of mefloquine.⁶⁷
39. Study participants reported a range of adverse events which were mainly neuropsychiatric. In the first contingent, 42 participants withdrew because of neuropsychiatric adverse events and in the second contingent, 20 withdrew because of such events.⁶⁸ These numbers far exceeded other adverse events recorded in the previous three clinical trials.⁶⁹

40. Nine serious adverse events occurred in those taking mefloquine, three of a neuropsychiatric nature. One participant had auditory hallucinations, which were consistent with an undisclosed prior history of auditory hallucinations. The study report said that another participant had a generalised seizure, among other adverse events. However, he was later reported to have had an undisclosed history of epilepsy. Another participant 'experienced depression, episodic anxiety, mild paranoia, short-term memory loss and suicidal ideation'. It said '[a]lthough he was taken off mefloquine and placed on doxycycline, his mental state continued to deteriorate' such that '[h]e was psychologically evaluated and returned to Australia'.⁷⁰

22.6 Mefloquine and tafenoquine clinical trials: long-term neuropsychiatric impacts

41. We received submissions from veterans who participated in Defence's mefloquine and tafenoquine clinical trials or who commented on the experience of other veterans with mefloquine and tafenoquine.
42. We also reviewed relevant research and previous reports and inquiries to obtain information about whether mefloquine and tafenoquine use is linked to long-term health impacts.

22.6.1 Individual experiences

43. Ex-serving members and their carers told us after participating in the clinical trial they experienced anxiety, nightmares and depression, and in some cases, suffered long-term neuropsychiatric effects.⁷¹ Some linked mefloquine to their own suicidal ideation.⁷² One partner, whose husband has now tragically died by suicide, linked mefloquine to her husband's earlier 'suicidal psychotic meltdown' and attempted suicides.⁷³ Another linked mefloquine and tafenoquine to adverse impacts seen in their fellow veterans.⁷⁴
44. Mr Stuart McCarthy is a former ADF member and clinical trial participant. He now advocates for better treatment of those who claim to suffer long-term neuropsychiatric effects from mefloquine and tafenoquine.⁷⁵ He participated in our roundtable held on 17 October 2023, along with Dr Jane Quinn, Professor in Veterinary Physiology at Charles Sturt University.
45. Dr Quinn's husband, a member of the British Armed Forces who was administered mefloquine, died by suicide.⁷⁶ Dr Quinn has undertaken advocacy and research into the impact of antimalarial medication and made a submission to this Royal Commission.⁷⁷ During the roundtable, both Mr McCarthy and Dr Quinn provided a lived experience perspective on potential adverse impacts of both mefloquine and tafenoquine.⁷⁸

22.6.2 What does the research tell us?

46. It is accepted that mefloquine and tafenoquine can cause short-term neuropsychiatric effects in some people. The question whether those effects persist in the long term or cause an acquired brain injury in some people is, however, inconclusive.
47. A 2020 report by the United States National Academies of Sciences, Engineering, and Medicine assessed the scientific evidence on the potential for long-term health effects following the use of preventative antimalarials by service members, including mefloquine and tafenoquine.⁷⁹ The report, conducted on behalf of the Veterans Administration, found current evidence was insufficient to associate anti-malarial drugs with psychiatric outcomes like anxiety, depression, and the development of post-traumatic stress disorder (PTSD) symptoms.⁸⁰ However, based on other factors like adverse events, case reports and public submissions, it also found there was a basis for further study of these associations.⁸¹
48. In 2017, a task force of Canadian Armed Forces personnel and civilians published the *Canadian Surgeon General Report*, which examined mefloquine use among Canadian military personnel.⁸² The report concluded that evidence on long-term health effects was weak. However, it recommended limiting mefloquine use to where other antimalarials are inappropriate or where a person has previously tolerated it with no negative side effects. The report also suggested enhancing precautionary screening and implementing a formal audit process to monitor screening and prescription practices. In making the recommendation, the report considered:
 - drug alternatives, for example doxycycline
 - the inadequacy of screening for contraindications
 - the lack of long-term safety evidence
 - the desire for alignment with allied forces
 - the desire to be responsive to the concerns of defence force members and society.⁸³
49. In 2015 and 2016, the United Kingdom House of Commons Defence Committee undertook an inquiry into the use of mefloquine by members of the country's armed forces.⁸⁴ The committee's report spoke of strong anecdotal evidence that suggested serving and ex-serving personnel had been adversely impacted by mefloquine, including through severe side effects.⁸⁵
50. It emphasised the majority of users will not experience side effects. However, given the risk and severity of them, the committee found mefloquine was not compatible with the duties of military personnel.⁸⁶ It recommended the UK Ministry of Defence designate mefloquine a 'drug of last resort', to only be prescribed under certain conditions. The conditions included if a member was unable to take other antimalarials, and if an individual risk assessment had been conducted.⁸⁷ The Ministry of Defence did not agree with this recommendation.⁸⁸ The committee also recommended further research be undertaken.⁸⁹

51. In 2018, the University of Queensland published research that examined the self-reported health of Defence members who had used antimalarials on deployment.⁹⁰ Defence and DVA commissioned and funded the study.⁹¹ The study involved Defence members who had been deployed in Bougainville, the Solomon Islands and East Timor. Respondents were asked to name what antimalarial drugs they had used, and to answer questions around their physical and mental health.
52. The research concluded that Defence members in Bougainville who had used mefloquine reported poorer self-rated health and more general health issues than doxycycline users. These findings, however, were based on a small sample (27). This result was not found across the East Timor sample.⁹² The study recommended that any future trials of antimalarial drug use in the ADF provide for short-term and medium-term health assessments.⁹³
53. In 2017, independent statutory body the Repatriation and Medical Authority undertook a review of mefloquine, tafenoquine and primaquine.⁹⁴ The Repatriation and Medical Authority sits within the veterans' affairs portfolio and its role is to determine if there is sound evidence linking injury, disease or death with war or defence service. If there is such evidence, it can issue legally binding statements of principles to guide DVA claims processing. Its review investigated whether mefloquine caused panic disorder and whether mefloquine, tafenoquine and primaquine caused chemically-acquired brain injury.⁹⁵
54. The authority declared there was 'insufficient sound medical-scientific evidence' that exposure to mefloquine and tafenoquine causes a disease or injury of the brain.⁹⁶ It also determined that panic attacks resulting from medications belong under a diagnosis of 'medication-induced anxiety disorder', covered by a new factor in its anxiety disorder statement of principle. The authority's investigation was reviewed by the Specialist Medical Review Council, which confirmed the authority's decision in 2018.⁹⁷
55. We note the report of the Senate's Foreign Affairs, Defence and Trade References Committee, *Use of the Quinoline Anti-Malarial Drugs Mefloquine and Tafenoquine in the Australian Defence Force*, tabled on 14 December 2018. The report contained 14 recommendations. On 15 March 2019, the Australian Government tabled its response, agreeing with 13 of the 14 recommendations without qualification and agreeing in principle with the remaining one.⁹⁸
56. The question of whether serving and ex-serving members suffer long-term neuropsychiatric effects from mefloquine and tafenoquine is of sufficient concern to warrant further research.
57. This Royal Commission calls for a longitudinal international study of a large cohort of defence personnel. They should be drawn from combined Australian and international defence forces that have used mefloquine or tafenoquine whether by way of clinical trial or on prescription. To control for combat, deployment and other defence exposures, such a study must include a correspondingly large cohort of civilian participants.

Call to action

A longitudinal international study of the impact of mefloquine and, separately, tafenoquine, should be undertaken in a large population of (i) civilian and (ii) Australian and international defence force personnel. The study's aims should be to ascertain whether mefloquine or tafenoquine or both are causally connected with long-term neuropsychiatric adverse effects.

22.7 Conduct of AMRI's mefloquine and tafenoquine clinical trials

58. In 2015, the Inspector-General of the Australian Defence Force (IGADF) undertook an inquiry following allegations of unethical, unlawful and negligent use of mefloquine during the trials conducted over 2000–2002.⁹⁹
59. The inquiry investigated whether the trials were conducted in line with ethical protocols and guidelines, and whether members were coerced or encouraged to participate (among other issues).¹⁰⁰ The inquiry involved:

gathering relevant evidence included the conduct of recorded witness interviews and seeking answers to questions by email from persons conducting and participating in the anti-malarial drug trials, an extensive review of the AMI trial file documentation, and the collection of supporting and reference documents¹⁰¹
60. The inquiry concluded that the trials met the ethical standards required by the National Health and Medical Research Council and the Therapeutic Goods Administration.¹⁰² It also found that participants in the trial had voluntarily consented to take part, and were informed of known side effects.¹⁰³
61. These findings, particularly around informed consent, do not align with some of the submissions we received. We summarise these issues in section 22.7.2.
62. For more on the IGADF, including perceptions it is not sufficiently independent of Defence, see Chapter 12, Role and functions of the Inspector-General of the ADF.

22.7.1 The ethical background

63. All clinical trials in Australia involving humans must comply with guidelines set out in accordance with the *National Health and Medical Research Council Act 1992* (Cth).¹⁰⁴ The National Health and Medical Research Council (NHMRC) first issued the *National Statement on Ethical Conduct in Research Involving Humans* in 1999. It has two key principles of ethical practice:
- respect, a key aspect of which is voluntary consent capable of being withdrawn any time
 - beneficence, the researcher's responsibility to minimise risks of harm or discomfort to study participants.¹⁰⁵
64. These principles recognise that particular care needs to be taken with participants in 'dependent or unequal relationships'.¹⁰⁶ This is 'where unequal power relationships exist between participants and researchers or where participants occupy junior or subordinate positions in hierarchically structured groups'.¹⁰⁷ Defence members are given as an example of such participants.¹⁰⁸

22.7.2 Issues raised in submissions

65. We received public submissions raising ethical issues around the conduct of the trials. The submissions suggest that participants were not in a position to consent freely, were discouraged from withdrawing from the trials, and were not provided sufficient opportunity to report adverse events.
66. We also note information provided by Defence which states that participation in the trials was subject to full voluntary consent, with ADF members choosing to opt in, and being free to withdraw at any time.¹⁰⁹
67. We have seen versions of the form that was used to obtain consent for the trials and we acknowledge that these do set out the terms around voluntary participation and opt-out.¹¹⁰

Consent

68. In his statement, Dr Daniel Mealy gave his opinion that:

Civilians need to understand that ADF members do not and cannot have the civilian equivalent of 'free and informed consent' when it comes to accepting or refusing essential medical care. This is because an entire war effort might be significantly hindered by individual soldiers refusing to be administered essential medical care, including effective and safe medications (such as anti-malarial prophylaxis) prior to entering an environment with inherent risk. However, trials of new drugs are different.¹¹¹

69. During the Mefloquine and Tafenoquine Roundtable, Mr McCarthy said:

the way that the Defence Force does its business, does its job, is just, you know, completely at odds with the way that [the] ... informed consent processes should be working.

...

The ... [study] that I was involved with was not as ... as extreme as that ['If you don't take this drug, you won't deploy']. It was a lot more subtle and a lot more nuanced ... [the] medical corps, lieutenant colonel turns up at your team site singing the ... the praises of this new wonder drug and basically give you a sales pitch ... one of the things by way of example I can recall is that part of the sales pitch for Tafenoquine by comparison with Primaquine was the part of the ADF policy for ... for Primaquine is that you're not ... not to drink any alcohol while you're taking that drug and the ... the standard course for that, I think, is 10 days or two weeks or 21 something like that. So we're told, 'Ah, look, you can't drink any alcohol. You have been on a long deployment, you go home.' If you take the normal drug without enrolling in this trial, you don't get to have anything to drink for 10 days. If you take Tafenoquine for three days and then you get to have a beer. So that's just one example of the informed consent process. And another thing I vividly remember being told ... was ... this drug is already being used by the military, the US Military.¹¹²

70. Consent was also raised in submissions that we received. One veteran said '[t]he only time a soldier truly volunteers is when they join'.¹¹³ The veteran continued, '[w]e never volunteered for this drug trial, we were coerced or threatened to ensure we participated'.¹¹⁴
71. As we noted previously in this chapter, there have been no adverse findings around the ethical conduct of the ADF regarding the antimalarial trials.
72. In response to the issues raised around consent, Defence told us it is 'highly conscious that in a hierarchical structure the capacity to give free and voluntary consent may be affected'.¹¹⁵ In recognition of this, Defence says it has a Human Research Ethics Committee (HREC) which has been operational since 1988. The HREC membership includes members from outside of Defence to ensure objectivity in assessing research protocols. According to Defence, consent is a key consideration in those assessments.¹¹⁶
73. Defence also noted the 2015 Inspector-General of the ADF Inquiry investigated claims that members were compelled to participate in the trials as a condition of deployment, and found this allegation to be unsubstantiated.¹¹⁷

Withdrawing from the trial

74. At the roundtable, Mr McCarthy told us that he believed participants were discouraged from withdrawing from trials after reporting adverse events.¹¹⁸ He said some participants in the second and fourth clinical trials in particular were experiencing side effects and:

they alerted the medics, they alerted, in some cases, their doctors, they alerted their chain of command ... corporal, sergeant ... team commander, company commander – and were told, ‘Nope, toughen up. Keep taking it. There’s no option’ ... [these are] the realities of working in a military environment. And, in a number of cases, that pressure to continue ... being a drug trial subject ... it reached the overt bullying stage in a lot of cases.

75. This experience is contrary to what Defence has told us. They state that ‘no member who requested to withdraw from the clinical trials was denied this request’.¹¹⁹

Reporting adverse events

76. We also heard that deployments offer fewer opportunities for clinical trial participants to report adverse events.¹²⁰

77. At the roundtable, Dr Quinn told us that Defence participants were engaging with clinical trial staff via the chain of command and Defence medical personnel, with significant intervals in the process.¹²¹ Mr McCarthy elaborated:

But when you look at the realities on the ground, I mean, if you’re a corporal section commander or platoon sergeant and you’re in some remote forward operating base ... a clinical trial protocol means nothing to you. The furthest down that would probably go would be through the medic’s chain. [It] [m]ight go to the regimental medical officer, but if you’re a corporal section commander or platoon sergeant, you wouldn’t even know what a clinical trial protocol is.¹²²

78. Defence told us that all participants who deployed had routine post deployment health assessments and periodic health assessments throughout their service, in addition to clinical presentations.¹²³ During the in-country phase of the trial, participants were reviewed face-to-face by the research team on a weekly basis and asked about any health issues. Defence acknowledges that on occasion a weekly review of the member was missed if the member was away from the location.¹²⁴

22.7.3 The conduct of the trials

79. We are not in a position to find that Defence personnel were unduly influenced or pressured to participate or continue to participate in mefloquine or tafenoquine trials by more senior members in the chain of command.
80. Nonetheless, our final report should remind Defence it must pay special attention to serving members’ ‘vulnerable subject’ status when conducting research.

81. Structural power imbalances exert a very real influence. In Chapter 7, Culture and leadership, we discuss the command and control environment and the influence this hierarchy has on members' capacity to exercise fully independent choices. We also discuss the role of stigma, and how cultural factors inhibit help-seeking.
82. With these contextual factors in mind, this final report should again remind Defence of its responsibility to minimise risks of harm or discomfort to research participants. The researchers in the clinical trials faced particular challenges in meeting this responsibility. They trialled a drug:
- known to cause severe adverse psychiatric effects in people with certain pre-existing adverse mental health conditions
 - in circumstances where the disclosure of pre-existing mental health conditions is affected by stigma, and is susceptible to systemic discouragement.
83. We stress the importance of strong ethics protocols, appropriate risk screening and providing suitable information and support for trial participants.
84. Further questions arise as to whether clinical trials can be properly managed and whether the welfare of trial participants can be properly monitored and evaluated in operational settings. Operational or deployment related needs – and not the detail of clinical trial protocols – dictate decision-making and place significant demands on both command and clinical trial participants. It seems logical to us that deployments may limit opportunities to report adverse side effects to clinical trial staff and geographical or other challenges may limit participants' access to care. These challenges must be appropriately managed.
85. Conducting clinical drug trials on Defence members on deployment must be rigorously managed in line with prevailing ethical standards and ensuring an appropriate risk/benefit ratio. Defence needs to be able to actively demonstrate how it overcomes the power imbalance within the relationship (given defence personnel are recognised as a vulnerable population). Additionally, Defence must be able to demonstrate it has obtained informed consent, which was freely given and can be subsequently withdrawn at any time, and minimise the danger stigma might have on participants' decisions.

22.8 Health care for mefloquine and tafenoquine veterans

86. We have been provided with information about Defence and DVA initiatives to support serving and ex-serving members concerned about the use of mefloquine and tafenoquine. These initiatives have come about largely in response to previous inquiries and concerns about potential adverse effects. We summarise two such programs below and note they have now ceased.

22.8.1 Anti-Malarial Health Assessment Program

87. Following the Senate inquiry, DVA established a national program to provide health assessments for ex-serving members concerned about the use of antimalarial medication.¹²⁵
88. The Anti-Malarial Health Assessment Program provided free health assessments for ADF members who had taken mefloquine and tafenoquine during their service. Following assessment, members would receive a confidential and customised health report, which could support further treatment. The program began in 2019, and ceased in 2023.¹²⁶

22.8.2 Mending Military Minds

89. The Mending Military Minds Pilot Program formed part of the Neurocognitive Health Program (NHP), which aimed to address the impact on cognitive functioning of long-term post-traumatic stress disorder (PTSD), the intensity and frequency of deployment, and the increasing self-reporting of cognitive decline in the veteran community.¹²⁷
90. Of the 58 clients included in the evaluation, nine (15.5%) of clients reported mefloquine/tafenoquine exposure, with four (6.9%) reporting this exposure as the reason for referral.¹²⁸
91. According to the evaluation report, most clients felt they were listened to and their concerns about their cognition were being comprehensively assessed, often for the first time. However, DVA decided not to implement the program on an ongoing basis, noting that the majority of participants were not found to have neurocognitive health deficits.¹²⁹ Instead DVA decided it was more suitable to provide neurological assessments to veterans under Non-Liability Health Care for mental health conditions.¹³⁰
92. This Royal Commission has been provided information and evidence about Defence or DVA developing good health service programs, only to discontinue them. The Defence Injury Prevention Program was one (see Chapter 15, Promoting health and wellbeing among ADF members, for more information). The 'Mending Military Minds' program would appear to be another.

22.8.3 Issues raised in submissions

93. We received submissions calling for Defence and/or DVA to respond to veterans' concerns about their participation in the mefloquine and tafenoquine clinical trials.
94. One submission said:

There needs to be better protocols about what medications / trial drugs they can give you when you are in the ADF. There needs to be choice about whether you are part of these programs or not. You should still have a human right to say no or to be told what was in the tablet.¹³¹

95. It went on to say:

DVA or Defence should track down every person who took the anti-malaria tablets and offer them assistance to lodge claims and get supports. They should give them information so them and their families understand what has happened to them and why they feel the way they do. If you don't know what's wrong how can you try and fix it? They need to be sending letters out / using social media to find people – if you find one you'll find 30. Most of them are still friends on social media.¹³²

96. Many veterans have concerns about the association of neuropsychiatric conditions and mefloquine and tafenoquine. Many have symptoms and deserve appropriate treatment.

97. See also Chapter 18, Health care for ex-serving members, and Chapter 24, Empowering veterans to thrive, for more on supports for veteran wellbeing.

98. We also discuss conditions prevalent in serving and ex-serving populations that are associated with increased risk of suicide and suicidality in Chapter 14, Introduction to health care for members and veterans. In that chapter we recommend the establishment of a brain injury program for serving and ex-serving members. The program should be available to those who are concerned about their exposure to mefloquine or tafenoquine, and it could build on the former Mending Military Minds program.

Endnotes

- 1 World Health Organization, 'Malaria', webpage, 12 January 2024, viewed 15 May 2024 (Exhibit J-01.008, DVS.2222.0001.1475).
- 2 World Health Organization, 'Malaria', webpage, 12 January 2024, viewed 16 May 2024 (Exhibit J-01.008, DVS.2222.0001.1475).
- 3 Department of Defence, 'Malaria and the ADF', webpage, (Exhibit J-01.009, DVS.2222.0001.1476).
- 4 Department of Defence, 'Australian Defence Force Malaria and Infectious Disease Institute', webpage, viewed 23 April 2024 (Exhibit S-01.024, DVS.0000.0001.9300).
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Royal Commission
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